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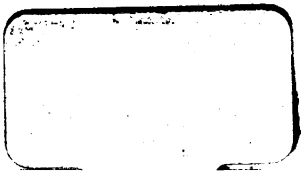

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PROCEEDINGS

OF THE

Kansas Medical Society.

THIRTY-THIRD ANNUAL MEETING.

TOPEKA, KANSAS.

WEDNESDAY, THURSDAY AND FRIDAY,

MAY 3, 4, AND 5, 1899.

A. S. HULING, REPORTER.

TOPEKA,

THE A. D. BAUER PRINTING CO.

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DR. MELVIN COLLINS, . . *First Vice President*, Oxford.
DR. S. V. FAIRCHILD, . . *Second Vice President*, Miltonvale.
DR. W. E. MCVEY, . . . *Recording Secretary*, Topeka.
DR. J. W. PORTER, . . . *Corresponding Secy.*, Litchfield.
DR. L. REYNOLDS, . . . *Treasurer*, Horton.
DR. S. G. STEWART, . . *Librarian*, Topeka.

1899.

DR. CHARLES GARDINER, . *President*, Emporia.
DR. R. J. MORTON, . . . *First Vice President*, Green.
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DR. W. E. BAKER, Chanute. DR. M. L. MCCREA, Winchester.
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DR. W. R. PRIEST, Concordia.

COMMITTEES.

BOARD OF CENSORS.

DR. A. B. PETERS, Mankato. DR. M. N. GARDNER, Greenleaf.
DR. D. W. BASHAM, Neal. DR. G. F. JOHNSON, Lakin.
DR. W. J. VAN EMAN, Leavenworth.

ON ARRANGEMENTS.

DR. J. C. MCCLINTOCK, DR. J. G. MULVANE,
DR. L. Y. GRUBBS, DR. D. K. LONGSHORE,
DR. J. E. MINNEY.

ON NEGROLOGY.

DR. R. S. DINSMORE, Troy. DR. W. H. WELLS, Coffeyville.
DR. J. DILLON, Eureka.

COMMITTEE ON PROGRAM.

DR. L. A. BUCK, Peabody. DR. C. F. LESLIE, Clyde.
DR. L. L. UHLS, Paola.

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SECRETARIES OF SECTIONS.

Surgery, ...	Dr. M. N. Gardner, Greenleaf.
Gynecology, ...	Dr. D. W. Basham, Neal.
Ophthalmology, . . .	Dr. D. F. Longenecker, Emporia.
General Medicine, . .	Dr. Ida C. Barnes, Topeka.

EX-PRESIDENTS.

Dr. S. B. Prentiss*	Lawrence	1859
Dr. J. P. Root*	Wyandotte	1860
Dr. C. A. Logan	Leavenworth	1866
Dr. Albert Newman	Lawrence	1867
Dr. John Parsons*	Mt. Pleasant	1868
Dr. M. Bailey*	Topeka	1869
Dr. M. S. Thomas*	Leavenworth	1870
Dr. Daniel C. Jones	Junction City	1871
Dr. W. H. Cochrane*	Atchison	1872
Dr. H. K. Kennedy	Topeka	1873
Dr. R. S. Redfield*	Ft. Scott	1874
Dr. Tiffin Sinks	Leavenworth	1875
Dr. H. S. Roberts	Manhattan	1876
Dr. W. L. Schenck	Osage City	1877
Dr. C. C. Furley	Wichita	1878-1879
Dr. B. E. Fryer	Ft. Leavenworth	1880
Dr. J. H. Stuart	Lawrence	1881
Dr. G. W. Halderman*	Paola	1882
Dr. D. W. Stormont*	Topeka	1883
Dr. C. H. Guibor	Beloit	1884
Dr. H. O. Hannawalt	Arvonia	1885
Dr. F. D. Morse	Lawrence	1886
Dr. L. A. Buck	Peabody	1887
Dr. J. Bell	Olathe	1888
Dr. C. C. Green	Winfield	1889
Dr. J. E. Minney	Topeka	1890
Dr. J. E. Oldham	Wichita	1891
Dr. F. F. Dickman*	Ft. Scott	1892
Dr. Geo. W. Hogeboom	Topeka	1893
Dr. W. R. Priest	Concordia	1894
Dr. R. S. Black	Ottawa	1895
Dr. F. M. Dailey	Beloit	1896
Dr. C. A. McGuire	Topeka	1897
Dr. James A. Lane	Leavenworth	1898

*Deceased.

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JOINT MEETING.

KANSAS MEDICAL SOCIETY, HOMEOPATHIC STATE MEDICAL SOCIETY, ECLECTIC MEDICAL ASSOCIATION.

WEDNESDAY, MAY 3, 8 P. M.

In pursuance of resolution adopted at the thirty-second annual meeting of the Kansas Medical Society, the members of the society assembled in Representative Hall, in the State Capitol, Topeka, at 8 o'clock P. M., Wednesday, May 3, in joint meeting with the Homeopathic Medical Society and the Eclectic Medical Association.

The meeting was called to order by E. B. Packer, M.D., of Kansas Eclectic Medical Association, who called upon Dr. W. E. McVey to act as Secretary.

Prayer was offered by Rev. J. D. Countermine, of the First Presbyterian Church, Topeka.

Governor W. E. Stanley was introduced, and delivered the address of welcome, as follows:

"I guess it is safe to address you as fellow citizens, although there might be a more dignified term. I am delighted to meet you this evening. I have delightful recollections of a physician whom I once knew, to whom some among my earliest recollections relate, a physician who had much to do with my earliest training. Of all the men whom I have known in this world, it seems to me the man whom I thought most of, respected most highly, and loved the most, was a physician. It may have begun in a childish fancy, but I know it made a deep impression upon my mind and heart. We hear a good deal said about physicians, much said in earnest, and much said in jest. I do not know that any other class of men, that those of any other profession, are made the butt of so many jests as the doctors. The doctor who assumes to cure disease was not the primary doctor. I think the primitive definition of that term is the man who is learned in general learning; the man who has graduated at college, and has a mind stored with learning in its various branches, would come within the primary definition. I have no doubt, however,

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that this definition would apply to many now called doctors, those who undertake to cure diseases.

"I am not a very old man, but my mind goes back to the old-time doctor as a large man, an ideal man in the community. No other filled so large a place, no one was supposed to come so near knowing everything as he did. Everybody, however, practiced medicine; the good housewife especially practiced medicine, with her roots and herbs, dosing the children regularly every spring. Most doctors practiced bleeding, there being a general agreement as to the necessity of letting out bad blood occasionally. There was another class of doctors, at least I heard of such old-fashioned doctors, whose principal reliance was upon the bark of a tree for all diseases, scraping the bark upward for an emetic, and downward as a physic. We talk about doctors disagreeing, as it was said of old, 'When doctors disagree, who shall decide?' But if doctors disagree it is quite true that you and I disagree and all men disagree. The poet has said:

> "'When ill, indeed,
> E'en dismissing the doctors does not always succeed.'

"Some of these old jests about doctors seem not likely to pass out. Doctors of medicine used to be like doctors of theology, always quarreling among the different kinds of doctors. The doctors of divinity formerly put out great volumes of written discussions; many sermons were preached concerning the different phases of religion, by the Methodists, the Baptists, the Presbyterians, but they have passed now to a larger faith. So you of different schools of medicine used to quarrel, the allopaths criticising the homeopaths, and both falling upon the eclectics, and all the other fellows. It is a satisfactory development, indeed, to look out upon this gathering, and realize that a platform has been established on which all can stand, wide enough to permit of those of every professional school extending the hand of kindly fellowship and brotherhood to those of every other. That you can at times close the books of your several schools, and meet harmoniously.

"In all the realm of business and professional life, there is no man that comes in so close touch with the homes and families of our country as the physician. They attend upon the first breath, the first gasp of life, the first opening of the eyes of every human being with helpful hand and sympathy. They stand beside the birthplace of the infant and the bedside of the dying.

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They cheer and strengthen the first steps of childhood and smoothe the declining pathway of age, and all along between there is reliance upon the confidential relation between the physician and the family into which he goes day after day. No other man upon earth fills altogether the same office. The minister gets pretty close to the family, but he does not come into that holy relation, that confidential relation, where all barriers are laid down, and all obstacles are removed, and where there is that altogether peculiar brotherly touch that exists between the family and the family physician.

"You have in your hands, brothers and sisters of this great profession, you have in your hands the holiest and most sacred duties that are held by any class of men under the sun. You are trusted more, relied upon more, confided in more; there are more pleading voices calling to you, more helpless hands reaching out to you for sympathy and help than to any others whomsoever, and when no one else can help, and when every other earthly help is taken away, except it may be a mother's last look and last clasp of the hand, the last look and the last call is made to the family physician. I would that the physicians of Kansas would rise up to this high responsibility, and we would have a profession here whose men and women would be as pure as our babes, with purposes as spotless as our Kansas skies.

"In this work of yours, this sacred calling of yours, this mission of yours, God help you, and God bless you."

Dr. J. E. Minney, seconding the address of welcome, said:

Mr. Chairman and Brethren: I feel very happy because I have been asked by the committee representing the three different medical societies, to second the address of welcome, and I feel particularly happy because I am permitted to be second to one of the best governors of one of the best States in the best country in the world. I feel happy tonight because of that union of spirit and that unison of purpose that we see manifested by those who are present. Quite a goodly number of folks are away tonight who might have been here. A little prejudice exists, but that fortunately is fast passing away, and we are broadening out, and we are trying to expand, and why should it not be so? We are certainly all brethren, followers of one great teacher, Hippocrates. Now, for fear my memory would not serve me properly, I wrote down the exact words as recorded, of Hippocrates, respecting the various schools of medicine, and I will read

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it to you to show you that what I said is what he said, if history can be trusted.

You remember in written history we are told that he lived some 350 years before the birth of Christ, and he wrote these words: "Some diseases can be treated best by contraries, and some by similars," hence, we find practically that Hippocrates is the founder of the so-called allopathic school, or that of contraries, as well as that of homeopathy or similars, for he says, "to cure mania give the patient a draft from the root of the mandrake in a smaller dose than will induce mania."

I am very happy tonight to see you all here, because of what you are and what you have done, and what you are proposing to do. It seems that it has been left to Kansas to institute this unison of the various schools of medicine, and to no other man in all the medical profession is more due than to Dr. Ochiltree, of Haddam, Kansas, in bringing this about. I am pleased and happy to meet you, because I have lived the life you are living; I have had the experience you have had. I have been at times buoyed up by a feeling of exultation, have rejoiced in my heart; and again, when the grim messenger Death came and carried away those that I was striving so hard to make live, or to help live, I like you have been depressed. But the Kansas doctor cannot be downed very easily; in, fact, he can do anything that can be done. This is a great saying, probably, and may be thought egotistical, but I think I know what I am talking about. When I came here fifteen or twenty years ago, all the most important cases were sent out of the State; any ordinary operation, especially when we entered the great cavities of the body, they sent out of Kanaas. But how is it today? That is all changed, and we find that almost any cross-roads doctor is prepared to undertake and competent to perform these operations involving the abdominal cavity, the thoracic cavity, or the pelvic cavity; not only entering, but removing a pathological condition and curing his patient.

It is astonishing. It seems like there is something in the Kansas soil and air that affects the doctor as it does the people in general, and we not only exert an increasing influence within our own borders, but we find Kansas doctoring away over in Manila. Why, they could not get along without the Twentieth Kansas, and you know that Holton furnished the doctor for the Twentieth Kansas, and the Kansas Medical College has furnished a student to help. Why we wonder about their terrible experi-

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ences there. You know it is hot. Somebody was saying the other day, it was so very hot that the water got to be so hot they could not put out a fire with it. Yet you know it was only the other day the boys swam a river there, and one of our brethren has suggested an explanation. These boys raised in Kansas have experienced the hot winds to that extent that the water don't affect them, and that is the best explanation I have heard.

Now, in behalf of the medical profession of Topeka, I want to say that I welcome you here to your own capitol, in this capital city. Before you leave us we want to shake each one of you by the hand, and we would like to break bread with as many of you as we can—if possible would like to break bread with all of you. We may get closer together while we satisfy the inner man. As the old saying goes, "If you don't see what you want, ask for it." If this does not satisfy you, why kick, because doctors can kick, and I don't have much faith in a doctor who can't kick, especially a Kansas doctor. Wishing you all the happiness possible, and that when you go home you will go invigorated and refreshed for the strife, I will bid you good night.

After an address by Dr. Menninger, of the Kansas Homeopathic Medical Society, Dr. Roby presented a poem, "The Army Surgeon."

Adjourned.

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PROCEEDINGS.

THURSDAY, MAY 5.

At 10 o'clock A.M., Thursday, May 5, 1899, the Kansas Medical Society convened in Thirty-third Annual Session, in the Representative Hall, in the Capitol, Topeka.

The meeting was called to order by Dr. J. P. Lewis, Chairman of Committee on Arrangements. Dr. James A. Lane, of Leavenworth, President, took the chair, and addressed the society. [See under title "Papers Read"].

On motion of Dr. Schenck the President's address was accepted and that portion in relation to sanitary science and sanitary reform referred to a committee of three.

The President appointed as such committee, Dr. W. L. Schenck, Dr. G. A. Boyle, Dr. H. Z. Gill.

On motion of Dr. Lindsay, the proceedings of last annual meeting having been printed in pamphlet form and distributed to the members, reading of the minutes was dispensed with.

By direction of the President, the Secretary called the roll of members of the Society.

On suggestion of the President, by unanimous consent, the list of members present, as shown by response to roll call, was adopted as the roll of the meeting.

The President appointed an auditing committee, to consist of Dr. W. J. VanEman, Dr. W. E. McVey, and Dr. C. F. Leslie.

Dr. L. Reynolds presented his report as treasurer, as follows:

Cash balance at last report		$127 62
Dues collected during interval		272 00
Total receipts		$399 62
DISBURSEMENTS.		
1898.		
May 5. W. E. McVey, mail and express charges on proceedings,	11 65	
W. F. Sawhill, stamps and stationery,	11 25	
A. D. Bauer, stationery	26 00	
16. W. E. McVey, publishing proceedings	100 00	
26. Stamps ($5.00), express charges (60)	5 60	
25. A. D. Bauer, stationery	29 00	
30. A. P. Barnett, stenographer	20 00	
31. Printing notices of dues	1 25	
June 2 A. P. Barnett, stenographer	15 25	
21 W. E. McVey, publishing proceedings	190 00	
July 12. Stamps and express charges	2 30	
Aug. 8. W. E. McVey, balance publishing proceedings	47 00	
Oct. 7. W. E. McVey, mailing reports	9 00	
Total Disbursements		$377 30
Balance in Treasury		$22 32

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Dr. Barnes presented the report of the Board of Censors, on applicants for membership, recommending the admission of the following named:

F. F. Allen, Neodesha; graduate of Chicago Medical College, 1873.

W. H. Robinson, Eudora; Kansas City Medical College, 1872.

J. D. Walthall, Paola; University of Michigan, 1883; N. M. K. of C., '99.

C. C. Goddard, Leavenworth; Bellevue Hospital Medical College, 1873.

Harriet E. Adams, Topeka; Kansas Medical College, 1894.

Edwin T. Shelley, Atchison; Medical Department University of Pennsylvania, 1881.

E. J. Norman, Eureka; University Medical College, Kansas City, 1897.

L. S. Trisler, Fall River; Medical College of Indiana, 1883.

Frank M. Tracy, Kansas City, Kansas; Physicians and Surgeons of Kansas City, Kansas, 1899.

E. E. Morrison, Great Bend; Barnes Medical College, St. Louis, 1896.

E. L. Simonton, Wamego; Kansas City Medical College, 1896.

J. M. Latta, Millerton; Michigan University Medical Department, 1883.

Henry J. Deaver, Robinson; Starling Medical College, 1892.

C. A. Milton, Dodge City; Rush Medical College, 1881.

Porter W. Barbe, Oswego; Cleveland Medical College, 1880.

Agnes McKee Wallace, Topeka; Kansas Medical College, 1893.

C. E. Judd, Topeka; Rush Medical College, 1898.

A. P. Rooney, Horton; Northwestern University, Chicago, 1897.

P. D. Hughes, Kansas City, Kansas; Fort Wayne College of Medicine, 1884.

D. E. Green, Pleasanton; University Medical College, Kansas City, 1895.

B. H. Leslie, Lawrence; University of Pennsylvania, 1868.

On motion, the report was accepted, and the Secretary was directed to cast the ballot of the Society in favor of the election of the persons named to membership; which being done, the President declared all duly elected in accordance with the report.

The President called for report of Committee on Legislation.

Dr. Lindsay, for the committee, reported that the committee

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met with the Committee on Health and Hygiene of the House of Representatives, and succeeded very well in preparing a bill that was acceptable to that committee. The bill so prepared was favorably received in the House, but when it came up for action the gentleman representing the President's city (Leavenworth) moved an amendment to the bill excepting osteopathy. This was fatal to the object of the bill, and we asked our friends to vote against it and allowed it to die. The gentleman referred to was an ex-Attorney General of the State of Kansas, who also moved to cut down the period from three years to two years.

On motion, the report of the committee was accepted and committee discharged.

The President announced appointment of Dr. W. E. Barker, *Chairman*, Dr C. F. Leslie, Dr. Chas. Gardiner, Dr. S. G. Stewart, to fill temporary vacancies in the Judicial Council.

Also, Acting Board of Censors, as follows: Dr. Ida C. Barnes, *Chairman*, Dr. B. D. Eastman, Dr. G. W. Hollenbeak. Dr. D. F. Longenecker, Dr. L. H. Murphy.

Also, Committee on Necrology: Dr. R. S. Magee, Dr. Andrew Sabine, Dr. C. M. Arbuthnot.

Attention was called to the remarks of Governor Stanley, at the joint meeting on Wednesday evening, in which he stated that he had found difficulty in selecting members of the State Board of Health, because of the fact that recommendations received neglected to include information as to the school of medicine to which the person recommended belonged, and asking that the different societies present to him the names of half a dozen reputable physicians, with information as to the length of time the persons designated had been engaged in practice.

It was moved that the President appoint a committee of five to select names to be presented to the Governor, in accordance with his suggestions.

Dr. W. R. Priest: I want to know in this connection whether this committee will be instructed in anyway in regard to the political affiliations of the physicians whose names are to be presented. I am a Democrat, and I am quite certain that the Governor will, and he probably should, appoint all Republicans on this board. I think it just as well to pass this matter over, and let the Governor appoint whom he will. It is quite clear that he wants to be informed in relation to the politics of those whose names are presented. The spoils evidently belong to the victor

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and we do not want to mix in the matter, and feel that when the matter is all over we were turned down without regard to professional standing simply because we were Democrats or Populists.

Dr. Wood: Half a loaf is better than no bread, and we would like to have members of this Society have some bread. Politicians are, of course, very apt to take politics into consideration, but I do not think we ought to ignore the Governor's suggestions. I think we ought to make our recommendations, and if he wants to know their politics, why tell him, and let him select as many as he will from the members of this Society.

Dr. May: I am heartily in favor of acting on the suggestion of the Governor. I believe it is entirely proper for this Society to recommend proper men for the Board of Health. We, as physicians, know more of the fitness of men for these duties than he does; and I think it is the proper thing to do.

Dr. Schenck: I came in while this matter was under discussion, and I guess it is a little like the colonel who reported while the battle was under way, and asked the general where he should go in. The general responded, "Go in anywhere, Colonel; there is splendid fighting all along the line." I have had a little experience in this matter, having served for quite a number of terms on the State Board of Health. When it was organized that admirable man, John A. Martin, was in the gubernatorial chair, and he sent to the State Medical Society and asked them to name eight or ten men who would be satisfactory to the medical profession, whom he might nominate or name as the State Board of Health. Since his time it has not been always after that wise. When Governor Martin retired and another person succeeded to the office, I was reappointed, although the other fellows with whom I had been serving were not. They were succeeded by men who were rather politicians than sanitarians. I went to the Governor and asked him how he came to reappoint me, and not the others. "Oh," he said, "you were recommended by the Senator from your county." "Well," I said, "this is a matter that should be above Senators, above politics; a matter in which ability should be considered rather than political affiliations. You will be kind enough to accept my resignation if I have been appointed because the Senator recommended me. While I may feel very much obliged to the Senator and to you, I cannot accept the appointment on that basis." I think it is eminently proper that the medical profession should suggest

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such individuals as they know to be qualified to discharge the duties of members of the State Board of Health.

Dr. Ochiltree: I think the best way out of this would be to do as the Governor suggests, to name six men from our Society irrespective of politics, not to appoint on this basis, but merely mention their politics.

The President stated the motion: Shall the chair appoint a committee of five to select physicians whose names will be presented to the Governor, from whom to select members of the State Board of Health?

The question was put on the motion, and it was carried.

The President appointed as such committee: Dr. W. R. Priest, of Concordia; Dr. Geo. A. Boyle, of Lewisburg; Dr. D. F. Longenecker, of Emporia; Dr. W. S. Lindsay, of Topeka; Dr. W. L. Schenck.

Dr. Ochiltree moved the appointment of a committee of three to consider and present amendments to the Constitution and By-Laws.

The question was put on the motion, and it was carried.

The President appointed as such committee: Dr. H. M. Ochiltree, Dr. S. E. Sheldon, Dr. J. P. Lewis.

The following resolutions were presented, referred from the joint meeting of Wednesday evening:

Whereas, It is a thoroughly established fact that until the information derived from vital statistics is furnished, adequate legislation for the suppression of preventable diseases can not be obtained; and,

Whereas, The medical profession is largely depended upon to furnish the facts and data for the guidance of legislation on public health and sanitation; therefore,

Resolved, That we, the representative societies of the medical profession of Kansas, in joint session assembled, will use our efforts, individual and collective, to make and induce all others to make promptly and fully the reports on vital statistics as required by the statutes and rules of the State Board of Health; and will in every legitimate manner aid in the promotion of the public health, and the work of the State Board.

Resolved, That we most heartily commend the work that is now being done by the State Board of Health in matters of vital sta-

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tistics. and in the publication of periodical reports; and also in the aid and counsel given by the board to city authorities in establishing public water supply, said counsel being given without cost to the local authorities.

ANDREW SABINE.
H. M. OCHILTREE.
CHAS. GARDINER.
O. J. FURST.

On motion of Dr. W. R. Priest, duly seconded, the resolutions were placed on file.

Dr. Gill stated that the State Board of Health had published last year a pamphlet containing the laws of the State in relation to matters in its care, and court decisions. A revision of this pamphlet has been prepared with the intention of distributing it in connection with the annual report of the board, to save expense in postage and wrapping. The annual report of the board has been in the hands of the printer since the 15th of February, but on account of matters coming from the Legislature which took precedence, the printer had not been able to complete the work. Dr. Gill said the pamphlet referred to would be furnished to members on application.

EVENING SESSION, THURSDAY, MAY 4.

Dr. Magee, Chairman of Committee on Necrology: We have the sad and painful duty, as your Committee on Necrology, of reporting on the death of five members since your last meeting, one year ago. Your committee has prepared, from such data as they have been able to obtain, a brief minute on the lives of each of these men. Some of them may be strangers to many of you, others went in and out before us for years, and were landmarks among us. One of them was almost, though not quite, a charter member of the society. The first one we shall notice is Dr. S. V. Fairchild.

Dr. S. V. Fairchild, the subject of this brief biography, died at his home in Miltonvale, Kansas, November, 1898, after a short illness or Bright's disease, at the age of 47.

The doctor was a native of Iowa, graduating from the College of Physicians and Surgeons, Keokuk, in 1880. He came to Kansas soon after his graduation, locating at Miltonvale, where he made his home until his decease. A wife survives him. Dr. Fairchild was a member of the U. S. Pension Board of Cloud county, a member of the International Association of Railway

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Surgeons, and local surgeon of the A. T. & S. F. R. R. The doc tor was an active member of the Kansas Medical Society since May, 1890, and at its meeting last year was elected its second Vice-President. To the friends and family of the deceased we extend our heartfelt sympathy.

The subject of this brief biography, Dr. S. B. Boyer, died at his home in Cherokee, Kas., March, 1899, of appendicitis, after a short illness. The doctor had reached the age of fifty years—followed his profession twenty-five years. He leaves a wife to mourn his loss. Dr. Boyer was an active member of the Southeast Kansas Medical Society, and had been a member of the Kansas Medical Society since 1892. The doctor was an able, active and intelligent practitioner. As a citizen and business man he was a commendable example. To the family and friends we desire to extend our sympathy.

The subject of this sketch, Dr. Chas. F. Smolt, was born in Paw Paw, Ills., in September, 1854. He came to Kansas in 1878, locating in Nickerson, and in December of that year was made the local surgeon by the A. T. & S. F. R. R. at that point. He held this position up to the year 1887 when he removed to Kansas City engaging in the real estate business.

He soon, however, tired of this and returned to his first love, the practice of medicine, locating at Newton, Kansas, remaining there only a short time returning to his old home in Nickerson, where he was again appointed the local Santa Fe surgeon.

After a short illness, he was called from his work, and died at Newton, Kansas, March 14th, 1899, at the age of 45 years. He leaves a wife.

He was a physician of State reputation. He was well known among railroad men and very popular. He was a brother-in-law of Mr. H. R. Nickerson formerly of the Santa Fe R. R., but now of the Mexican Central R. R. Dr. Smolt was a man of marked professional ability and general attainments. He loved his profession and admired high professional qualifications and integrity in his associates. He detested quackery and did not permit himself to associate with those who belittled the practice or medicine for the money there was in it. His genial nature made him many friends and his general intelligence made him a citizen valuable to his town, and foremost in every enterprise conducive to its growth. For the past fifteen years he had been an active member of the Kansas Medical Society. He was a modest, unassuming, intelligent practitioner of medicine.

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The subject of this sketch, Dr. Curtin Chapin Morgan, was born Oct. 24, 1860, in the State of Iowa. After a brief illness he died of brain trouble at his home, April 9th, 1899, a little past thirty-eight years of age. The doctor's early life was spent in the State of his birth, where he obtained his early education in attendance at the Iowa Central University. In boyhood he determined to be a physician, first graduating in a pharmaceutical course. Not satisfied with this vocation he entered Bellevue Hospital Med. Col. of New York City; completing the course in 1889. Again, in 1896, he took a post graduate course in one of New York's post graduate schools, aspiring to higher attainments in his chosen profession, which he loved. Though young in years, his mind was stored with rich experiences. He delighted to relieve suffering and pain. He possessed a steady nerve and an unquivering hand. In emergencies, he was cool, calm and deliberate. In 1896 Dr. Morgan was married to Mrs. Della C. Morgan, the widow of his deceased brother, Dr. H. W. Morgan, and while in New York City taking his special course, she was stricken and died, a bride of but a few months. I wish to say a word of tribute to the memory of this deceased lady, that she was a lovable and worthy woman, industrious in pursuit of her studies and a hard-working student. The doctor in 1896, was elected to the chair of Bacteriology in the Gross Medical College, in Denver—this, he declined. In 1887, he was elected to the chair of Pathology in the Kansas Medical College, of Topeka. This position he filled acceptably for one year, when he resigned, that he might devote himself more completely to his practice. Dr. Morgan was an active member of the Clay Center Presbyterian church and for several years a member of its Board of Trustees. Dr. C. C. Morgan was an able practitioner. He fitted himself by an early education, and the regular and post graduate courses, for the highest attainments in his profession, thus enabling him to successfully cope with his fellow practitioner. In many respects he was superior; he had few equals. He was an active member of the Kansas Medical Society, having been a member since 1894. He was also Local Surgeon of the U. P. R. R. and member of the Pension Board of Clay county. To the friends and members of the family of the deceased we extend our sincere sympathy.

Dr. W. W. Cochrane, an old and respected citizen of Kansas, died at his home in Atchison, Kansas, January 14, 1899, after a

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long and serious illness. The deceased was born in Owen county, Kentucky, in 1820. His ancestors were of Scotch and English descent, a combination which gave the doctor his firm will, and yet never asserting himself in any way to offend.

At the age of 28 he received his degree in medicine at the Louisville Medical College, in the class of 1848. His early practice was in the States of Louisiana and Mississippi, continuing there until 1859, when he removed to Atchison, his present home. In 1862 he was married to Miss Mary D. Stuart, of Palmyra, Mo., who, with three children, survive him. Until a few years ago, when the doctor retired from practice on account of advanced age, he was the leading physician of Atchison county. He became a member of this Society April 15, 1868, at its meeting in Leavenworth. He was its President from 1872 to 1873, and was annually elected its Treasurer thereafter until 1890. For a number of years Dr. Cochrane was a member of the Atchison city council and was always foremost in the promotion of enterprises, and the city never had a more persistent worker for its growth and upbuilding. He was a ripe scholar and a close student. A highminded honorable gentleman and practitioner of the Regular School. At all times courteous and affable, yet firm and steadfast in his convictions. We looked to him, while in the years of his profession, as a father in medicine highly esteemed and worthy of our highest appreciation of his efforts to raise the standard of medicine in the State which he loved, and for its interests he lived and gave his best strength and talents for nearly forty years. In the reports of the Society, we find Dr. Cochrane's report on "Anesthetics," in 1881, which, though nearly twenty years ago, reads well and shows advanced thought. Also in 1882 a report on "Obstetrics," and an essay on "Cholera" in 1888. These articles from the doctor's pen showed him to have been a thorough student in medicine, and ever ready at all times to impart to his fellow practitioners the knowledge he had gained by practice, experience and observation in his field of labor. To the family and friends we extend our heartfelt sympathy.

R. S. MAGEE, *Chairman.*
C. M. ARBUTHNOT,
ANDREW SABINE,
Committee.

Moved that the report be accepted and adopted by a rising vote.

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The President put the question, and the report was adopted, in the manner indicated.

The President: The report of the committee, bringing to our attention the death of such men as Dr. Cochrane, admonishes me that the document which I hold in my hand is more and more every day becoming one of historical value. It is the first constitution of this society, adopted in 1859. There are perhaps many members who would like to sign this copy of the constitution. For convenience it will be left with the Treasurer, Dr. Reynolds, for signatures.

The report of the Stormont Library Committee was read by the Secretary, as follows:

Mr. President: Your committee on Stormont Medical Library are again compelled to report that few additions have been made during the past year, for the same reason that has existed during the past four years, i. e., absolute lack of shelf room. Not deeming it wise to buy books to stow away in boxes, we have refrained from purchasing anything but a few books, and keeping up previous contracts. However we are at last assured that shelf room will be available this coming summer, and we will endeavor to bring our collection up to date.

Your committee wish to make a special request of every member to send in such list as they think should be in our collection.

The attached report of the State Librarian shows the condition of the available funds and assures us of an opportunity to use the same.

Respectfully,

C. A. McGUIRE, *Chairman.*

TOPEKA, KANSAS, May 3, 1899.

Statement of book purchases made from Stormont Fund since July, 1898.

1898.		
July 14.	A system of Diseases of the Eye	$ 6 00
Sept. 1.	Annual Analytical Cyclopedia of Practice of Medicine	6 00
Sept. 22.	Vol. XIV Twentieth Century Practice of Medicine	6 00
	Vol. XV Twentieth Century Practice of Medicine	6 00
Dec. 10.	Annual of Universal Medical Science, 5 vols	7 50
1899.		
Jan. 12.	The Lancet, subscription one year	6 00
Feb. 3.	Vol. XVII Twentieth Century Practice of Medicine	6 00
	Vols. II, III, American Encyclopdia of Practice of Medicine	12 00
Mar. 28.	Vol. I American Encyclopedia of Practice of Medicine	6 00
	Total	$63 50
Unexpended balance of Stormont Fund in the treasury		$3,606 69

ANNIE L. DIGGS,
State Librarian.

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The amendment to Constitution presented by Dr. Furst at last annual session came up for action, as follows:

Resolved, That section 1, article V, of the Constitution be amended by inserting in lieu of the words "in the city of Topeka," the words "at such place as may be selected by the society."

The question was put on the adoption of the resolution, and it was lost.

The Secretary read communication from the Kansas State Homeopathic Society as follows:

"*Resolved*, That the Kansas State Homeopathic Society favors the holding of a joint meeting in 1900 as was done last year and this. Adopted May 4, 1899.

"The homeopathic members of committee for joint session are as follows; Dr. W. B. Swan, Topeka; Dr. F. M. W. Jackson, Emporia; Dr. W. E. Buck, Kingman. The other two members will be appointed from the place where the societies meet.

Respectfully, H. C. OATMAN, *Secretary.*"

Also from Kansas Eclectic Medical Association as follows:

"Eclectic members of committee for joint session, 1900: E. B. Packer, M. D., Osage City; W. C. Hamilton, M. D., Topeka; T. N. Watts, M. D., Alma; B. J. Alexander, M. D., Hiawatha; W. Y. Vance, M. D., Horton.

Respectfully, E. B. PACKER, *Secretary.*"

Dr. Ochiltree moved concurrence in the action of the Homeopathic and Eclectic Societies, and that provision be made for joint meeting next year.

Dr. Bryan: I presume what little I may say will have no influence on the vote upon this resolution. I do not know how others may feel in this matter. If I could sit down with you privately and talk with you about this matter you might speak very freely, but it seems hard to get an expression out of men in these meetings, that really expresses what they feel. I have had an experience that has made me very firm—not bitter—in opposition to any recognition of an irregular organization calling itself a medical society. There are good and familiar reasons for this, if men will post themselves. I find the men in favor of these joint meetings, this recognition of irregulars, are those least posted in medicine, and particularly in the United States. After the experience I have had personally, besides my teaching, to attempt to harmonize, to meet in the same organization with these irregulars, is to fight against all the principles that I

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have imbibed in medicine, and all that I have been taught. Now last night sitting here myself, from this platform I heard this society called an allopathic society. I must say that to you who are getting a little gray, like myself, it must have been pretty hard as it was for me to keep my seat.

The regular profession has never adopted the name allopath. The homeopaths under Hahnemann adopted the name by which they distinguish themselves. It was an offshoot; it went off and away from the regular profession of medicine; it called itself a new school, the homeopathic; the new homeopathic school of medicine, and they all call themselves that today. Now, assuming they are competent to name themselves, and we adopt the name and in turn call them homeopathists, are we not still competent to name ourselves? Must we give to those who are opposing us, and denouncing us for their own benefit, the right to name us by a name which they have chosen as one of opprobrium, and shall we sit quietly and accept that name? The lawyers tell us that silence gives consent. You must enter your protest, or else the cause goes against you. I therefore protest against any outside society naming the regular profession of medicine. We are regulars, and I say it with a full knowledge of what it means, we are the medical society of this country and the world. Show me an eclectic or a homeopath who has given us anything new, during their life time. Today you go into their offices, and I am sorry to say it, and I am ashamed of our publishers for it is a thing that ought not to exist, the only men among them who have come to know anything at all are men who will show our publications in their libraries. We have educated them, what education they have.

So with the eclectics. They use our books. You meet them and talk with them personally and they will tell you so, and show you the books on their shelves. I have had this said to me right at home, not here, said to me by a homeopath with whom I am personally intimate: "Because I am a homeopath it does not prevent me from giving medicine." I knew of a case in which he ordered fifty ounces of quinine at one time, he and his partner. I said to him, "What, you homeopaths order quinine in fifty ounce cases?" He said, "Oh, yes, we use that much in a year." He did not see the point, did not see the drift. "Why doctor" I said, "you astonish me, ordering fifty ounces of quinine." "Why," he said, "I was giving Mr. Brown five grain doses the other day." He seemed to see what I was driving at, and then

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he said, "Do you think if I am a homeopath I can not give medicine as well as you? When I think it necessary to give a big dose, I give it." Then I said, "That is just the trouble with you." Coming to the point. There has got to be something in a man's mind before he can get into these irregular schools, that he has got to be willing either to be a scoundrel and practice that which he knows to be false to gain therefrom, or else he is ignorant; and I cannot attribute it to ignorance every time.

Dr. Ochiltree: I presume that, in my indorsement of this resolution, I will have to confess that I am among a rather ignorant class, not thoroughly posted on the subject of medicine. But there is one thing that the gentleman has demonstrated to me, that some things are an annoyance to him besides dogs. I do not believe the gentleman was here last year, and he has not a full understanding of the resolution. It is not a resolution to fraternize down here, or to hold any discussion with them. It is merely a combined meeting to start the meetings of the several societies, and to show that the old feeling of animosity that has animated many in the past has passed away. Now, it is a fact that the homeopathic schools recognize us, and we recognize them. If a person attends three years at a homeopathic school, and wishes to attend one of our schools allowance is made, and the same is true of the eclectics. The homeopathic schools are the equals of our own. I am not a homeopath; I do not prescribe homeopathic remedies. As far as principles are concerned persons can disagree in medicine as well as in religion but still in a harmonious manner. The gentleman is no doubt aware that we have eminent representatives of the regular school of medicine who recognize some value in homeopathic principles, among them John Ald of Philadelphia, one of our most progressive practitioners. I have no doubt the gentleman himself, in some instances, prescribes very small doses.

But there is another point I want to bring out. The laity are looking at us critically; they are regarding the position of antagonism we assume, and we cannot make the advance in medicine we wish to if we continue in this spirit of antagonism. It is not a step forward to vote this resolution down. I regard it as a step forward to adopt this resolution, and I do not think anything is better calculated to advance the practice of medicine than the continuance of these meetings. The Governor of Kansas congratulated us last evening on these joint meetings. I trust this will be considered in an enlightened way. Dr. Roby

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just told me there was but one dissenting vote in the homeopathic association. The eclectics also have adopted the resolution. We do not have to adopt their principles by continuing in this way. One of the greatest reasons is this: I wish to break down the prejudice that exists in the minds of the laity, in regard to the position we hold toward one another. It has been a great obstacle to medical legislation. I do not expect to accomplish everything by holding up this spirit, but to continue these joint meetings will do much to break down this feeling. We are compelled to associate with them on the State Board of Health, where they are appointed as our peers, and because of the opposition that is known to exist between us, the laity hold us in a measure of contempt. All have the osteopaths and Christian scientists to fight, and in this the homeopaths and eclectics are united with us, as much in earnest as we are, and a degree of union at least should be continued for this purpose.

Dr. Mitchell: I think this question is one of importance, and it demands our early consideration. It is either for the advantage of our membership individually, and for the advantage of our organization as a society, or it is a disadvantage to us individually and to our society; and it is either an advantage or a disadvantage to the science of medicine. The main reason presented here to this society, Mr. President, in support of this resolution, is that we may be able to break down this feeling of animosity, this prejudice which seems to have been existing, and perhaps does exist to a certain extent, between the medical societies, to-wit, the regular school, the homeopathists and the eclectics. It seems that the old saying, "Consistency is a jewel," applies in this case as well as in others. If it is sustaining and promoting animosity, and if it is sustaining and promoting and keeping up prejudices existing between the different associations, to abstain from union in these meetings, does not our refusal to consult in the sick room around the sick patient promote animosity and prejudice? If it does in the one case, it does in the other. Then, to be consistent, if we find it necessary to continue these union meetings in order to break down this animosity and this prejudice, why not go into the sick room and consult with reference to the treatment of our cases? It seems to me that in the support of this resolution we become inconsistent, we become unreasonable and place ourselves in a position which is certainly very embarrassing, if we pretend to maintain the principles upon which we have stood and which we have maintained in years past.

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What good results have followed from these union meetings? You say it promotes sociability, it breaks down prejudice, and so on. We go home, and among individuals who are members of these other societies, there are men whom I recognize as good citizens, as excellent neighbors, and warm personal friends. In our homes we have no animosities against each other as citizens. But on what basis can we meet together to discuss subjects pertaining to medicine? If we can, we can consult in the sick room as consistently, and by so doing as truly promote the cause of medicine.

Dr. Minney: I am not dead set on this by any means, and I would like for each one of you to think for yourselves. What was it that advanced homeopathy in the beginning, what but persecution? In the face of prejudice homeopathy flourished. They tried to beat the thing down by refusing to associate with it, refusing all countenance to it. The people met this course with the cry of "Persecution, persecution!" and built it up. Now, homeopathy is no more like what it was twenty years ago than is the regular practice of medicine, just as much change in the one as in the other. Now, my object is union, harmony. To Dr. Mitchell, I say if he is called into consultation by a homeopath, it is a mistake if he does not go, and at the bedside of the patient you can show the superiority of learning and methods. That is the only place to show it. And the man who does not go when so called, and consult at the bedside of a patient, talk about the case, loses a golden opportunity, as I believe. Some of the best men in New York and Pennsylvania recognize them in that way. I have no love particularly for Hahnemann, though I would remind Dr. Bryan that Hippocrates was the founder of it. He said some diseases must be cured by contraries, and some by similars. He was the founder of both theories of medicine, and history proves it.

Now, I want to know how we are going to advance the practice of medicine in this city and in this State by going back on what we have done. The thing to do, in my opinion, is to cast aside prejudice in the name of humanity, and for the good of the medical profession do not let us advertise ourselves by refusing to meet with them and showing what we have that is good by comparison.

The President: I will ask the indulgence of the society a moment before putting the question. I opposed the joint meeting last year, and one more year has convinced me more fully that

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there is no object in holding a joint session, and scarce any reasonable excuses can be given for holding a joint session. If there are any I would like to hear them, before the question is put. We put ourselves into a false position when we sit in this hall like a whitened sepulcher filled with dead men's bones. We did not dare to make use of the greatest privilege we have in this country, we were not allowed free speech. Not one of you could get up here and express himself. Yet we posed here as harmonizing and fraternizing, with what? What is the regular school of medicine? Why, it is anything under the sun that will alleviate suffering, and help mankind to live longer and happier. If these, with whom we are asked to fraternize had advanced as Dr. Minney says they have, they would be here in this society. And when Dr. Minney states to one of our younger members, Dr. Mitchell, that he ought to consult with a homeopath, can any honest man consult with one who relies upon a work on materia medica which devotes thirty pages to prove the efficacy of one-millionth of a grain of charcoal? There is no harmonizing the regular school of medicine with any such fad. I would just as soon fraternize with Lydia E. Pinkham or any of her kin. Is it to save car fare that we participate in these joint sessions? I think there is no one of us that could not make more than the difference by spending the evening at home, rather than by pretending to meet with a class of men whom we cannot consult with.

Dr. Stewart: This meeting of the different schools of medicine looks beautiful to the people outside, to see harmony existing between disagreeing principles and disagreeing schools; at first thought it strikes us very pleasantly. But on considering it, it does not look to me so pleasant; indeed, it seems rather a bitter dose. Now, these homeopaths and eclectics, while they believe honestly in their principles, we can respect them. If homeopathy had advanced to such an extent as our friends here assert, its flag would be changed, its motto would be changed. They started out with a motto. There is no such motto on the flag of the regular school of medicine as "*contraria contraris curantur.*" We are not allopathists. When we accept the label of allopathists we are simply taking up with the title which was given us by Hahnemann, in derision, and we ought not to accept it. There is no common ground on which the schools so far apart in medicine can come together except for the purpose of securing legislation. When it comes to consulting, when it comes to dis-

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cussing medicine, we can not come onto the same ground at all, can never work from the same standpoints at all. We go directly opposite. There is one way in which we can meet those with whom we differ, and that is this: When you are called to see a case, go and see it, give the benefit of your opinion when there is any chance to mitigate or relieve suffering, but remember you are a representative of medicine and never make any concession to what you are convinced is error. But the point about it is, it is humiliation to stand up before the world apparently as one, when we are just opposite, and I am not in favor of this resolution.

Dr. Sullivan: I do not believe in the principles of Hahnemann, and I am not in harmony with those principles. I was taught by one of the most radical men in the regular profession, and when he talked upon these subjects he was very earnest in his remarks. I was pretty thoroughly instilled in his teachings. Afterward, in order to find out what there might be in homeopathy, I took a post graduate course in homeopathy. I must say I have met frequently in consultation with doctors of the homeopathic school. I practice for the good of the people and of my pocketbook. By working for my pocketbook I work for my family. No man follows any profession regardless of his pocketbook, unless he is a millionaire. Wherever we can do good it is our duty to do it. If we can meet with the homeopaths and we can agree it is well enough, and so we may do good. If we can not agree we can withdraw. There are a few good things in homeopathy. It is said here that progress has been made. I want to ask here who is there in our school of practice that gives the same dose as he did twenty-five years ago? I don't think there is one. It was our enormous doses that started Hahnemann on his course. We opposed them at the beginning and have opposed them every since, and they have thrived on it. I am a member of the board of pension examiners with a homeopathist, and he is a gentleman in every respect. I have taught also with doctors in homeopathic schools, and there is little difference in their practice. Some of them stick closely to Hahnemann, and others are as far apart from it as you or I. We find a great many of them that we cannot meet with, and some that we can. I believe the more we meet with them, the more we can bring them to us.

Dr. Sexton: I do not believe we ought to adopt this resolution. I do not say it with any spirit of antagonism to homeo-

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pathy, or with any feeling against it, but simply as a matter of principle. I believe to meet with them as we did yesterday for the purpose of trying to put ourselves right before the laity, is much like the old plan of marrying a drunkard to reform him. If we adopt this course which has been counseled here, just as soon as we have won over the homeopathists and the eclectics, we will have the same course open to us in regard to the osteopaths and the christian scientists. If we are right, as we believe we are, let us go ahead with malice toward none, but still pursuing our own way independently.

Dr. Esterly: I am a very young member with you, a member of two years standing, but I remember that two years ago the object of this joint meeting was medical legislation, and I would ask what has been accomplished? Now as an amendment to this resolution, I move that the delegates from this society to the American Medical Association be instructed to favor a joint session. How many men here who are in favor of these joint sessions here would be in favor of a joint session of the American Medical Association?

The amendment was not seconded.

The question was put on the adoption of the resolution for a joint session in 1900, and it was lost.

FRIDAY, MAY 5, 1899.

The President presented an invitation to members of this society to attend the session of the Missouri Medical Society, at Sedalia, May 16, 17 and 18.

Dr. Boyle called attention to the matter of recommendation of names to the Governor for appointment as members of the State Board of Health. As the regular profession in this State outnumbered others in the proportion of about ten to one, many members had suggested to the committee the propriety of submitting ten names to the Governor instead of six.

Dr. Priest, as chairman of the committee having this subject in charge presented the report of the committee as follows:

Your committee appointed to select names for the Governor's consideration for members of the State Board of Health, beg leave to report the following: Dr. S. W. Williston, Lawrence, Douglass county; Dr. O. J Furst, Peabody, Marion county; Dr. R. J. Morton, Green, Clay county; Dr. G. A. Boyle, Louisburg, Miami county; Dr. L. M. Powell Topeka, Shawnee county; Dr. J. P. Lewis, Topeka, Shawnee county.

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Further, we respectfully recommend to the Governor the appointment of a competent sanitary engineer on the State Board of Health.

W. R. PRIEST, *Chairman.*
GEO. A. BOYLE.
W. S. LINDSAY.
D. F. LONGENECKER.
W. L. SCHENCK.

Dr. McGuire: It has been remarked that the regulars largely outnumber the other schools, and that we should present more names. I see that the names recommended by the committee include two from Shawnee county, both capable men, both friends of mine, and I have no disposition to oppose either of them. It is quite certain that in any event but one will be selected from Shawnee county, and it seems to me advisable that the list should be enlarged, geographically as well as numerically. I would urge, and move, the addition of the name of Dr. Hollenbeak, of Gray county, a man in every way fitted, and who at the same time has considerable weight and influence politically.

Dr. Minney seconded the recommendation of the name of Dr. Hollenbeak.

Dr. Priest: It makes no difference how many names we recommend. The law regulates the matter, and under the law we can not have more than five members in any event. Last year the board was organized with five regulars, three homeopaths, and two eclectics. The committee has distributed the names over the State as well as possible. The Governor suggested the recommendation of six names, and it seemed best to limit the list to his request.

Dr. McGuire: By the nomination of two men from one county, the list is restricted in other parts of the State. I would still urge the recommendation of Dr. Hollenbeak.

The question was put, and the amendment was agreed to.

The report as amended was then adopted.

Dr. Schenck, as chairman of the committee to which was referred the recommendations embodied in the President's address, reported by resolutions, as follows:

Whereas, It is a lamentable fact that little or nothing is done towards scientific sanitation in many of our Kansas towns and villages; and,

Whereas, We believe that the first and best step towards the establishment of a practical application of the rules of sanitary science is to teach this science to the people: therefore,

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Be it Resolved, That the teachers of our public schools should be compelled to pass an examination upon sanitary science, and to teach it in our public schools.

W. L. SCHENCK.
G. A. BOYLE.
H. Z. GILL.

On motion, the report was accepted and the resolution adopted.

The same committee further reported:

Whereas, It is a well known fact that many young men have been allowed to enter and graduate from some of our medical colleges who have not had even a common school education, and who could not pass the necessary examination for a third grade teachers certificate; and,

Whereas, This condition of affairs is detrimental to the advancement of medical science and tends to lower the standard of the medical profession: therefore,

Be it Resolved, That it is in the interests of the medical profession that all persons proposing to enter the medical profession shall give proof of a preliminary education equal to that prescribed by the National Association of Medical Colleges; and that such proof or evidence shall be shown by an examining committee independent of the medical college to which said person or applicant shall make application for admission as a matriculant.

W. L. SCHENCK.
G. A. BOYLE.
H. Z. GILL.

On motion, the report was accepted and the resolution adopted.

The same committee further reported:

The Kansas Medical Society believes that the civilization of the age, and good government, require national departments for the promotion and preservation of national peace, protection and prosperity, and for the development of the various resources of the State; and it further believes that all these are because man is, and that they emphasize the importance of a national department of health, that shall provide for the protection of every citizen against the varied sources of disease and premature death, and for the development and preservation of the physical, intellectual and moral forces of the citizen, preserving all that is best in man and securing that evolution which is the birthright of every human being; therefore,

Be it Resolved, That we earnestly implead our representatives

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in the National Congress to use their influence to secure the desired legislation.

Resolved, That copies of these resolutions and preamble be sent to the National Pure Food and Health Commission, and to the representatives and senators from Kansas in the National Congress.

W. L. SCHENCK.
G. A. BOYLE.
H. Z. GILL.

On motion, the report was accepted and the resolutions adopted.

The President announced the committee on nomination of officers for the ensuing year as follows: Anderson county, Dr. A. M. Davis; Barton county, Dr E. E. Morrison; Brown county, Dr. H. J. Deaver; Chase County, Dr. J. F. Shelly; Cherokee county, Dr. E. B. Payne; Clay County, Dr. R. J. Morton; Cloud county, Dr. W. R. Priest; Crawford county, Dr. H. Z. Gill; Douglass county, Dr. E. D. F. Phillips; Elk county, Dr. W. H. Smethers; Finney county, Dr. Andrew Sabine; Ford county, Dr. C. A. Milton; Gray county, Dr. G. W. Hollenbeak; Greenwood county, Dr. D. W. Basham; Johnson county, Dr. D. Hamilton; Kearney county, Dr. G. F. Johnson; Leavenworth county, Dr. C. C. Goddard; Lyon county, Dr. D. F. Longenecker; Marion county, Dr. O. J. Furst; Miami county, Dr. Geo. A. Boyle; Neosho county, Dr. W. E. Barker; Ottawa county, Dr. L. H. Murphy; Pottawatomie county, Dr. C. W. Rairdon; Shawnee county, Dr. C. A. McGuire; Smith county, Dr. W. C. Bower; Washington county, Dr. M. N. Gardner; Wyandotte county, Dr. J. E. Sawtell.

In the absence of Dr. VanEman and Dr. Leslie, the president appointed Dr. Barker and Dr. Bowers to fill vacancies on the auditing committee.

FRIDAY AFTERNOON, MAY 5.

The auditing committee presented the following report:

We, your auditing committee, have examined the books of the Treasurer and find them correct, and that at the beginning of this session there was a balance of $22.32 cash on hand.

W. E. MCVEY,
W. G. BARKER,
W. C. BOWER.

On motion, the report was received and committee discharged.

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Dr. Ochiltree, for the committee on revision of the constitution and by-laws, presented the following report:

Mr. President: Your committee, to whom was referred the amendments to the constitution and by-laws, beg leave to make the following report:

That Article 3, sec. 1, of the constitution be amended to read as follows:

The permanent members shall consist of those who are members of this Society at the time of the adoption of this constitution, and who shall continue to conform to the by-laws, and have maintained their membership as provided by the by-laws.

Physicians who are graduates of reputable medical colleges, and who are regular practitioners of medicine in the State of Kansas, and who shall be recommended by two members in good standing of this Society, may become members by application.

The following application shall be filled in and signed by the applicant, and signed by two members of the Society in good standing, and accompanied by the membership fee and one year's dues.

Form of Application.

(Date).....

I hereby make application for membership in the Kansas Medical Society, and enclose herewith five dollars, for membership fee (three dollars), and one years's dues (two dollars). I am a graduate of.....of the year....., and a regular practitioner in the State of Kansas; and I hereby subscribe to the rules and regulations of the Kansas Medical Society, and agree to abide by the same.

Name.....

Address.....

Recommended by.....

.....

We have examined the credentials of....., and recommend him for membership in the Kansas Medical Society.

.....	.....
.....	.....
.....	.....

Board of Censors.

The application shall be referred to the Board of Censors who shall attest the same, after which it may be acted upon by the Society.

That section 4 of Article 1 of the by-laws be amended by striking out the words, "and collect all monies due the Society, and

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receipt for, and turn the same over to the Treasurer, taking his receipt therefor."

That section 6 of Article 1 of the by-laws be amended by adding the following sentence after the words "funds of the Society:" "and collect all monies due the Society, and receipt for and turn the same over to the Treasurer, taking his receipt therefor."

That section 3 of Article 2 be amended by striking out the words, "prepare the programme."

That section 1 of Article 7 be stricken out.

That resolution adopted May 15, 1897, be stricken out.

Respectfully submitted.

H. M. OCHILTREE,
S. E. SHELDON,
J. P. LEWIS.

The report was placed on file and referred to the next annual meeting of the Society.

The Committee on Nominations reported as follows:

For President—Dr. Charles Gardiner, Emporia.
First Vice President—Dr. R. J. Morton, of Green.
Second Vice President—Dr. C. A. Milton, of Ford county.
Recording Secretary—Dr. W. E. McVey, of Topeka.
Corresponding Secretary—Dr. J. W. May, of Kansas City, Kans.
Treasurer—Dr. L. Reynolds, Horton.
Librarian—Dr. S. G. Stewart, Topeka.
Member Judicial Council—Dr. W. R. Priest, Concordia.

On motion of Dr. Sexton the report was accepted and adopted as read, and the President declared the persons named in the report the duly elected officers of the Society for the ensuing year.

Dr. Reynolds declined the election as Treasurer, and stated that he had advised the members of the committee that he was not a candidate, and was unable to serve as Treasurer.

Dr. Gill: The committee understood that Dr. Reynolds desired to decline to serve, but he had performed the duties of the office so faithfully the committee considered it proper to reelect him, hoping he would conclude to accept.

Dr. Reynolds insisted upon his resignation.

On motion of Dr. McGuire the resignation of Dr. Reynolds as Treasurer, was accepted.

Dr. Minney moved that Dr. L. H. Munn. of Topeka, be elected Treasurer.

The question was put and it was carried, and the President an-

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nounced the election of Dr. Munn in place of Dr. Reynolds, resigned.

The President called attention to the claim of Dr. Daily on account of a pledge made by him on behalf of this Society of a contribution of one hundred dollars to the Rush monument fund. With the proverbial tendency of Kansans to get to the front, while in attendance on the American Medical Association as a delegate from Kansas, he had pledged a contribution of one hundred dollars in behalf of this Society, and he had advanced and paid the money. The Society had never in any way acknowledged the action, had never assumed the obligation nor ever moved to pay it back to Dr. Daily. The President suggested the advisability of appointing a committee to devise ways and means to reimburse Dr. Daily, or to make proper recognition in some form. Some State societies had voted contributions immediately on the presentation of the matter, and wrote checks at once for considerable amounts. It would be proper to appoint a committe of this Society on the Rush Monument Fund.

Dr. Gill: Dr. Daily no doubt felt that he was under some obligation to maintain the dignity of the Kansas Medical Society, and in his generosity he gave his check, which I assume has been paid. I do not assume that Dr. Daily intended to obligate the Society, as a society, or to draw on its funds as a society, but he depended upon the individual members of the society. And if he counted on our honor and on our interest in this great matter, which is a national matter, I think it was a generous act on his part, and I think it would be a proper and a noble thing to take some action in regard to it. I am not quite prepared to offer a motion, but it seems to me that we, as individual members of this Society, might see fit to donate a certain amount to reimburse Dr. Daily. Of course, it was not right for Dr. Daily, from a legal standpoint, to implicate this Society to the extent of one hundred dollars.

On motion of Dr. Priest, the matter was laid upon the table.

Dr. Porter moved that the committee on arrangements for the next annual meeting be directed to provide for a three days' session, no business to be transacted during the first two days of the session, except election of members, the third day to be devoted to business.

Dr. Ochiltree: It strikes me that this is unnecessary and rather unwise. The little business that comes up before the So-

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ciety, comes up necessarily, and all members cannot stay until the third day. The business is more interesting when it comes in connection with the papers than if it were all transacted at one session. We do not need a whole day for business, and I like the present plan best.

Dr. Ward: I move to amend that there be a two days' session, and that the regular order of business be not taken up until the afternoon of the second day. It appears to me that all other business can be transacted in a day and a half.

Dr. Priest: The way we have been doing the last twelve or fifteen years is all right. No one is disposed to take advantage, and everything has gone off well. At nearly every morning session there is business to come up and dispose of, and when a later hour comes everything can be carried off smoothly. It does not seem to me good policy to make any change.

Dr. Eastman: I would call attention to the fact that we can not by our action bind the next meeting. It will take up business as seems necessary in its own wisdom.

Dr. Porter: My object is to endeavor to secure a certain portion of time solidly for the discussion of papers, for purely literary and professional work, and try to avoid matters breaking in and taking an undue amount of time, as this matter has today.

On motion the matter was indefinitely postponed.

Dr. McVey, from the publishing committee, reported that the proceedings of the last annual session had been published in the *Kansas Medical Journal*, and had been printed in pamphlet form and furnished to the members of the Society. Accepted.

The same committee further reported as follows:

To the President of Kansas Medical Society: We have received the following proposition for printing the proceedings of the Society:

Gentlemen: I will print the proceedings and papers read at rate of sixty-five cents per page, same style type as proceedings of 1896-97, bound in 50-pound paper or tag board. Bound in cloth, $50 extra. This for 350 copies.

Or will print in same type and style as the proceedings I furnished the Society in 1898 for $225, paper; $50 extra for cloth. 350 copies. Revise proofs furnished.

(Signed) A. D. BAUER.

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We, your committee on publishing, recommend that the proposition of Mr. Bauer to print 350 copies of proceedings, like pamphlet of 1898, with cloth cover, for $275, be accepted.

W. E. McVEY,
GEO. A. BOYLE,
W. C. BOWER.

Dr. Reynolds moved that 275 copies be ordered in paper binding, provided it could be done for a proportionate amount of the sum stated in the proposition for the larger number.

Dr. Porter suggested publication in the *Western Medical Journal* at Fort Scott. He was willing to pledge that publication would be made without charge.

In response to inquiry whether each and every member would have to become a subscriber to the journal at Fort Scott to get the proceedings, Dr. Porter said, "Not necessarily."

Dr. W. E. McVey: There has been considerable objection to dependence upon publication in newspapers. There is no record of the business proceedings of the Society. It is difficult to get the record from such publications. Many members called attention to this want of a record last year, and the necessity for publication in pamphlet or book form then seemed quite apparent. There is now a hiatus of two or three years in the Society's records, there being no other record than the publication in the *Kansas Medical Journal.* The number proposed to be printed affords sufficient to send a copy to each member, to exchange with other societies and to place copies in libraries where they are often sought for reference.

The question was put on the amendment, and it was lost.

On motion, the report of the committee was adopted.

Dr. Porter moved that any member of the Society be granted the right to publish a paper read by him before the Society in any regular medical publication.

The question was put on the motion, and it was carried.

On motion, secretaries of sections were elected, as follows:

Surgery—Dr. M. N. Gardner, Greenleaf.
Gynecology—Dr. D. W. Basham, Neal.
Ophthalmology—Dr. D. F. Longenecker, Emporia.
General Medicine—Dr. Ida C. Barnes, Topeka.

Dr. M. B. Ward offered the following resolution:

"*Resolved*, That the thanks of this Society be exte[illegible] to the committee on entertainment, for the very efficie[illegible]anner in

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which they have managed this session of the Kansas Medical Society, and for the fine program arranged for the entertainment of the members and their ladies on the evening of the last day's session."

The question was put, and the resolution adopted.

The Secretary reported the following papers on the program received but not read, the several authors being prevented by various engagements from attending the session:

"Syphilis in the Family and the Community," by Prof. W. S. Gottheil, New York City.

"The Need of Medical Legislation in Kansas," by Dr. B. S. Stewart, Netawaka, Kansas.

"Orthopedic Surgery," by Dr. J. T. Axtel, Newton, Kansas.

"The Refraction of Trachomatous Eyes," by Dr. E. E. Hamilton, Wichita, Kansas.

On motion, these papers were received and read by title, and referred to the committee on publication.

The President: I wish to thank the members of this Society for their indulgence and extreme good nature, and for the manner in which my decisions, sometimes apparently arbitrary, have been accepted. We have tried to follow the printed program, but some have been compelled to leave before they were reached in the regular order, and I have used my best judgment in these matters. It hardly tends to encourage us when we see a tendency of men to come here and spend just time enough to say that they have attended this great progressive Society, only to say that they have been here, and perhaps that they have been invited to read a paper. They are interested enough to get here just in time to read their papers and then skip away again. I am glad to say, however, that there are many who come and remain through the entire session.

Dr. Porter moved that the thanks of the Society be tendered to the President for the courteous and efficient manner in which he had performed his duties.

The question was put by the Secretary, and the motion was carried unanimously.

Then adjourned.

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PAPERS READ.

Dr. F. C. Hotz, Chicago, Ill., read a paper on "The Mutual and Intimate Relationship Between the Eye and the Nervous System."

Mr. President and Members of the Kansas Medical Society: Your invitation to deliver an address to your Society at its annual meeting has given me far more pleasure than you can imagine. To be invited to address a society of the representative physicians of a great State, is certainly a great honor and a personal compliment which would awaken very pleasant feelings in the breast of every man. But what pleased me the most was the thought that a society of practitioners was desirous of listening to the address of an oculist, for I thought I could see in this desire an indication that the wide gulf that has so long separated general medicine and ophthalmology is being filled up, and that physicians are beginning to realize that a familiarity with the discoveries of modern ophthalmology may often be of material assistance to solve many a difficult problem in their daily practice, just as we oculists have long come to the conclusion that we must keep in touch with the progress of general medicine.

When in the middle of this century the genius of Helmholtz opened with his ophthalmoscope to our gaze the interior of the eyeball; when the brilliant mind of Donders unravelled the mysteries of refraction; and Græfe, the greatest master in the art of clinical observation, enriched the pathology and therapy of eye diseases with new discoveries in rapid succession, ophthalmology suddenly became an independent and very progressive branch of medical science. But in cutting loose from surgery to which it had belonged, it seemed to have become disconnected entirely from medical science; for it goes without saying that physicians have been accustomed to pay little or no attention to the diseases of the eye; to them the domain of the human anatomy enclosed within the orbit, was a *terra incognita* like the dark continent.

I have often met physicians telling me they did not know anything about the eye and its diseases; they seemed almost proud of their ignorance, or, at least, took it for granted as the most natural thing that a physician was not expected to pay any attention to the eye. But why not? Is not the eye as good and precious a part of the human body as the throat, or the stomach,

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or the uterus? We have throat specialists, but on this account does any physician think it unnecessary to study the diseases of the throat? And would he ever dream of letting a patient, consulting him for a simple sore throat, go to a specialist for the reason that *he* did not know anything about throat troubles? Would he not fear that such admission would hurt his reputation? We have gynecologists, too, but I am sure no practitioner is willing and ready to concede to the specialist the female pelvis as his exclusive domain; on the contrary, he tries to keep himself well informed of its diseases and their treatment so that he himself can take care of these cases, unless their very serious nature should demand the services of the more experienced specialist.

Take any organ of the human body and we see physicians pay the closest attention to its diseases; only when they come to the eye their interest suddenly drops to zero, and patients with the simplest kind of an ocular affection are turned away from their door and are compelled either to seek the services of a specialist or to take their chances with home remedies, christian science, etc. I believe this indifference of physicians to everything concerning the eye is partly due to the fact that eye diseases, though often fatal to the visual organ, do not kill the patient; and hence, lack that unmistakable *demonstratio ad oculos* so often furnished by the fatal termination of diseases of other organs to forcibly convince us of their serious effect upon the general health.

Every physician understands that gastric disorders, liver complaints, kidney diseases, in fact the diseases of any organ which plays a vital role in the assimilation of food or in the elimination of the waste products, must naturally alter the chemic qualities of the blood and unfavorably affect the nutrition and functions of the whole organism. Hence, physicians regard even the most trifling disorder of these organs as worthy of their full attention and in cases of general malnutrition carefully examine the various organs for the purpose of locating, if possible, the cause of the constitutional disturbance.

But that little thing, the eyeball, which has nothing to do with the biologic processes of nutrition, is not suspected of ever causing any disturbance reaching beyond the bony confines of the orbit. The eye has never been included among the possible disturbing factors affecting the health of an individual, and physicians have become accustomed to exclude it from the list of their investigations.

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But the bony walls of the orbit do not isolate the eye from the rest of the body; it stands in constant and intimate communion with it; it is frequently affected by diseases of distant organs, and though its diseases do not threaten or shorten a man's life, they often inflict so much suffering that the sufferer may well feel disposed to doubt whether life is worth living.

The intimate relationship existing between the eye and other parts of the organism is most strikingly illustrated by the influence diseases of the nervous system so frequently have upon the eye, and, *vice versa*, ocular disturbances have upon the nervous system. And it is to this highly interesting subject I wish to turn your kind attention for a few minutes.

Do not fear, gentlemen, that I shall put your endurance, physical and mental, to a severe test; do not apprehend you will have to listen to a lecture highly charged with confusing technicalities and bewildering Græco-Latin terms which so luxuriantly thrive upon the rich soil of ophthalmology. I have always thought it showed very poor judgment when in a general medical society an oculist read a paper very learnedly discoursing technical details, which, to be sure, were highly interesting to the specialists, but far beyond the scope of the general practitioners; and the bored and tired expression I have noticed upon the faces of the audience on such occasions rises most vividly before my eyes as a reminder not to commit a similar blunder. I shall not lead you through an ophthalmic maze, that would puzzle and fatigue you; for my desire is not to smother but to awaken your interest in questions relating to the eye; and I know I shall succeed if I present to you in plain language a few plain facts showing the influence of nervous diseases upon the eye, and then, another series of facts illustrating the influence of ocular diseases upon the nervous system.

The Influence of Diseases of the Nervous System Upon the Eye.—Diseases of the nervous system affect the eye very differently according to the different nature of the neurosis; functional neuroses cause functional disturbances; organic nervous diseases produce structural changes in the eye.

The *functional neuroses* in which you may look for ocular disturbances, are neurasthenia and hysteria, while it is a noteworthy fact, that in chorea, though twitchings of the facial muscles are almost always present, the ocular muscles are very rarely involved; and epilepsy also does not affect the eye, except that during the paroxysms its muscles participate in the general muscular convulsions.

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In *neurasthenia* ocular disturbances belong to the most frequent and prominent complaints. Neurasthenics cannot endure much physical or mental exertion; their nerve force is quickly exhausted, their muscles become easily tired, and a little work is apt to cause a nervous collapse with aches and pains all over the body. The eye muscles are not exempt from this general debility, and since reading, writing, sewing and similar occupations require the service of muscles (chiefly the ciliary and internal recti muscles) neurasthenics experience all the symptoms due to the quick fatigue of these muscles, though they may enjoy normal vision and normal refraction; they can read but a very short time, because their vision becomes either blurred (fatigue of the ciliary muscle), or unsteady and vacillating (fatigue of the recti muscle), and their eyes and head soon begin to ache. This incapacity for prolonged near work is, of course, much accentuated if the eye muscles are unduly taxed by existing anomalies of refraction.

Another visual disturbance often accompanies the paroxysms of the neurasthenic headache or migraine, popularly called "sick headache." In probably one-half of the cases of migraine the attack is ushered in by peculiar visual phenomena; either the patient can see but one-half of an object, for instance the right half of a persons face (hemianopsia) or his vision is suddenly blotted out entirely (scotoma or "blind spell"); or he sees passing before his eyes dazzling flashes of light and luminous rings constantly changing in colors like a kaleidoscopic play (scintillating scotoma.) Patients are often greatly alarmed by these blind spells: it is therefore well for you to understand their purely neurotic character and harmless nature and to know that they are not indicative of any danger to the sight; but at the same time it is well always to bear in mind that acute glaucoma is also ushered in by sudden obscuration of vision and violent headache with nausea and vomiting. In migraine the blind spells usually lasts but a few minutes to half an hour and precedes the headache and nausea, and the eye presents an absolute normal appearance; in glaucoma, the blind spell occurs simultaneously with the headache and lasts as long as the headache and the eye shows by its engorged bloodvessels, enlarged pupil and increased tension, the unmistakable signs of glaucoma.

Hysteria is so closely related to neurasthenia that we are not surprised by finding the ocular disturbances of the one should also be frequently noticed in the other neurosis. And indeed

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are quick fatigue of the eyes and visual disturbances of varying degrees from slight impairment to total blindness no uncommon symptoms in hysteria. This hysterical amblyopia, as it is called, may affect both eyes, but usually it is confined to one eye. It occurs quite suddenly, varies in degrees almost daily and disappears as suddenly as it came; and the eyeground shows no ophthalmoscopic changes.

The *organic diseases* of the nerve centers affect the eye in various ways, but the optic nerve is the chief sufferer. In acute meningitis the optic nerves are frequently involved in the inflammation which extending to the optic disk becomes directly visible to us by means of the opthalmoscope. In doubtful cases the ophthalmoscopic evidence of optic neuritis is a very valuable means of deciding the diagnosis; and in tubercular meningitis its specific nature may sometimes be determined conclusively by the ophthalmoscopic discovery of tubercles in the eyeground. Optic neuritis is also frequent in brain abscess, especially when they have attained considerable size. The inflammation is often unequal in both eyes; but it does not follow that the more marked neuritis is always found in the right eye if the abscess is in the right hemisphere and in the left eye if the abscess is in the left hemisphere; hence we cannot draw any positive conclusion from the unequal intensity of the neuritis as to the probable site of the abscess.

That the cerebral irritation produced by sunstroke may effect the optic nerves has been first pointed out by me twenty years ago. (Notes on intra-ocular lesions produced by sunstroke. *American Journal of the Medical Sciences*, July, 1879.) The optic neuritis in these cases seems, however, to be of a rather mild and transient type, not likely to lead to atrophy of the optic nerve and permanent damage of vision. In all my cases at least, the inflammation readily subsided and the eyes recovered normal acuity of vision.

Tumors in the brain frequently lead to great impairment of the vision or total blindness. In the majority of cases the ophthalmoscope shows an enormous veinous congestion and edematous swelling of the optic papilla; and though this condition known as "choked disk" is occasionally found with other diseases, its occurrence in connection with cerebral tumors is so prevailing that the ophthalmoscope may often decide the question of the nature of the existing brain lesion. Tumors growing at the base of the brain may cause, by direct pressure, paralysis of one or

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the other motor nerves supplying the eye muscles; they may also cause blindness of one eye by pressure upon its optic nerve; or affect in a peculiar way the vision of both eyes by pressure upon one optic tract. And we are often enabled to determine the anatomic location of the morbid growth by the eye symptoms.

Atrophy of the optic nerves and paralysis of ocular muscles are also frequent in brain syphilis, in those degenerative processes known as general paralysis and multiple sclerosis, and especially in *locomotor ataxia.* In the latter disease ocular disturbances make their appearance often at a very early stage before other symptoms of ataxia are manifest. This is particularly true of the paralysis of the ocular muscles; so that a paralysis of a muscle suddenly appearing without cause in an apparently healthy individual should always give rise to the suspicion of beginning tabes; especially if this paralysis is of short duration and reappears either in the same or any other ocular muscle at various intervals. A very characteristic and constant ocular symptom of locomotor ataxia is the contracted pupil (often unequal in both eyes) and its failure to react to light, while the eyes show no signs of inflammation (past or present) of the iris, which is the only local disease causing contraction and non-reaction of the pupil.

A great many more facts could be cited illustrating the influence of nervous diseases upon the eye; but I have promised you not to become too technical and tiresome, and I have therefore restricted this review to the most prominent landmarks, believing they are sufficiently strong and conclusive proofs to convince you that nervous diseases are a frequent source of functional and organic disturbances of the visual organ.

Let us now turn our attention to the reverse side of the relation existing between the nervous system and the eye. Let us see whether we may find as good and strong evidence to prove that eye troubles are a frequent cause of nervous disorders.

The Effect of Ocular Affections Upon the Nervous System—When speaking of the "blind spells" in sick headaches, I have already called your attention to the fact that *acute glaucoma* causes one-sided headache, nausea and vomiting of the same violence as migraine. I wish to impress this fact once more upon your mind, because I have in my practice met with several cases in which the glaucomatous origin of the headache and gastric disturbance had not been recognized and those nervous symptoms had been treated as neuralgia, migraine or gastric troubles. One

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of these was a particularly sad one. A woman whose right eye had been blind for many years, was seized by the most violent left-sided headache, nausea and frequent vomiting. Her physician pronounced her trouble gastritis and "sick headache"; and even when the patient told him her sight was becoming poorer every day he paid no attention to the eye, but assured her that the sight would return as soon as her stomach trouble was cured, and the neuralgia relieved. Having implicit faith in her physician, the poor woman abided by his word, and though soon her sight was gone, she patiently endured the constant agonizing pain, day and night, and hopefully waited for the day when the dark cloud would be lifted from her eye. For two weary months she suffered and hoped; but, finally her endurance was exhausted and much against the will of her physician she consulted an oculist. Alas, too late! The glaucoma had done its deadly work only too well; although the iridectomy promptly reduced the high tension and at once relieved the headache and all the other symptoms, the sight did not return; the optic nerve fibres had been completely destroyed by the long lasting high tension.

Can you imagine a more shocking result of a physician's blunder for which there is absolutely no excuse, for the signs of acute glaucoma, the engorged veins of the eyeball, the dull cornea, the dilated and immobile pupil and the high tension are so plainly marked out that he who only takes the trouble of looking at the eye cannot fail to see them.

Many inflammations of the eye cause more or less disturbance in the various branches of the trigeminus. The dull browache of corneal inflammation, the frontal headache, in simple conjunctivitis, after reading, the throbbing neuralgias of the jaws in iritis and the splitting headaches in cyclitis are too well known instances of the disturbing influence of ocular affections upon the nerves. Not so well known is the fact that even a simple stye may cause severe headache and easily be overlooked as the etiological factor of the headache.

But the inflamed eye may occasionally cause a more serious neurosis than headache. As a case in point, let me give you a brief history of a case which has been recently reported. (*Klinische Monatsbl. f. Augenheilkunde*, Aug. 1898.) A young man of regular habits and good health had an iritis of the left eye after an attack of influenza in December, 1891. In spite of atropine treatment the iritis persisted and soon the patient was seized with fainting spells and convulsions which induced him

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in Feb., 1892, to go to the hospital. There his nervous seizures were recognized as typical epileptic paroxysms which became more frequent and intense in spite of the use of bromides and hpynotic suggestions. As the patient's left eye still showed signs of inflammation an oculist was called who advised the enucleation of the eye, not because he suspected it to be in any way responsibie for the epilepsy, but because he wished to relieve the patient of all further troubles which the persistent inflammation of the hopelessly blind eye was sure to cause in the future. The eye was enucleated in April, and the epileptic attacks ceased at once after the operation never to return.

Observations like this are highly interesting and instructive, but very rare; and we cannot be surprised that the eye was not suspected as the disturbing element in this case. In most instances, however, the inflammation which exerts a disturbing influence upon the nerves, attracts the attention of both the patient and the physician and it is not difficult for the latter to recognize the causal relation between the ocular inflammation and the nerve pains.

But in the largest number of nervous affections caused by the eye, this little organ presents a perfectly healthy and normal appearance; it looks so natural and innocent that no one would suspect it to be capable of doing so much mischief, and although in a number of instances the patient is inclined to the belief that there is some connection between the eyes and his nervous troubles because he finds they are either brought on or greatly aggravated by the use of the eyes, yet a great many patients have no such experience; they have no fault to find with their eyes and think it an absurd idea when they are told the cause of their nervous sufferings may possibly be found in their eyes.

Oculists have long been acquainted with the fact that in many people the use of the eyes for near work, (reading, writing, sewing, etc.,) was invariably followed by pain in the eyes and violent headache. In the majority of these cases the distressing symptoms were found to be the result of an overtaxed accomodation; and in a smaller number they were attributed to the strained effort of the weak internal recti muscles to maintain the proper convergence of the eyes at the reading distance. And as the accommodation (that is the adjustment of the sight for short distances) is also accomplished by muscular action (the ciliary muscle) it is evident that in all these cases the headaches are caused by the over-exertion of ocular muscles or by *eye-*

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strain which is the generally accepted term to designate an excessive demand upon either the ciliary muscle or any of the extrinsic muscles of the eye.

Very soon, however, it was found that eye-strain was not limited to the near work, but covered a much wider field. It was found that far-sighted and astigmatic persons who can see things at any distance with distinctness, are unconsciously straining their accommodation; their ciliary muscles are incessantly at work from the moment they wake up in the morning until they go to sleep at night, while under normal optical conditions of the eyes distant objects are seen distinctly without the aid of the accommodation and the ciliary muscles are set to work only to adjust the vlsion for the near range. But the eye with normal refraction is greatly in the minority; the far-sighted and astigmatic eyes constitute the majority. It, is, therefore, not surprising that these optical conditions (far-sightedness and astigmatism) are encountered as a frequent cause of eye-strain.

And as to the extrinsic muscles it was soon learned that the causes for strained action are not restricted to the internal recti muscles, but are just as frequently, if not oftener, found in the other muscles.

The easy and accurate execution of those rapid, lightning-like movements of the eyeball in looking from one object to another; the easy and steady maintenance of our gaze upon an object, require a mechanism of well-balanced muscular forces. The perfect equilibrium of these forces alone renders it possible that both eyes look straight at a distant object when all the muscles are in a state of relaxation or physiologic rest. If, from whatever cause, one muscle becomes stronger or weaker than its antagonist, the muscular balance is disturbed and the eye naturally inclines to turn toward the stronger muscle. If the disturbance is considerable, the eyeball is permanently turned toward the stronger muscle, as in convergent squint, but if the disproportion of the muscular tensions is not very great, the tendency of the eyeball to turn toward the stronger muscle is opposed and the eyes held straight in the interest of binocular vision by a strenuous effort of the antagonist muscle, the external thus opposes the tendency of the eye to turn inward; the internus opposes its tendency outward, the inferior rectus its upward, and the superior rectus its downward tendency. Now, imagine this muscular struggle is incessantly going on from morning till night, and day after day, and you will understand

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that the disturbed equilibrium of the eye muscles furnishes another important and frequent source of eyestrain.

As every muscular contraction represents the expenditure of nerve force, it is evident that the coutinuous activity of the ciliary muscle of the far-sighted and astigmatic eye and the constant efforts of the extrinsic muscles to restore the lost equilibrium consume daily a much greater amount or nerve force than nature has provided for the use of the eyes. And as a person who daily spends more money than he earns, will inevitably become bankrupt, so this excessive expenditure of nerve force is likely, sooner or later, to lead to nervous exhaustion manifesting itself in the various forms of functional nervous derangements.

That such are the frequent consequences of eye-strain, has been proven beyond the possibility of a doubt; and the evidence is accumulating so fast, that the time is near at hand when physicians will consider it their duty to make, or have made, a critical examination of the eyes in the persistent headaches of school children; in intractable headaches of adults; in nervous dyspepsia and unaccountable insomnia; in neurasthenia and even in chorea and epilepsy.

The recognition of eye-strain as a frequent cause of all these functional nervous disorders and the possibility of relieving untold numbers of sufferers by removing the cause of eye-strain is one of the greatest achievements of modern Ophthalmology, an achievement the medical profession of this country has particular reasons to be proud of, because it is chiefly and pre-eminently the work of American Ophthalmologists!

DISCUSSION.

Dr. May: I think this Society is under obligations for the elegant paper just read by Dr. Hotz, as it is a very valuable paper indeed. Not any more so to the oculist than to the general practitioner, those who make up the main body of this society. I believe that we very frequently, as general practitioners, I know that I did in the past, make mistakes concerning eye diseases as producing general diseases, and *vice versa*, and I believe that that mistake is very often made. Now, for instance, as the doctor has well set forth, symptoms developed in the extrinsic muscles of the eye are very frequently the result of some general disturbance of the system; there is general muscular disturbance, anemia, what not. The trouble is not in the eye at all, but yet the symptoms are referable to the eye. Now,

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I believe that a great many of these eye-strains, so-called, can be relieved and must be relieved to a great extent by the treatment of the general system. There is another thing connected with these eye cases, and that is the peculiarity of the intimate relation of the eye to the general system through the blood and through the nerves. There is very close association, the circulation of the blood extends through the eye, and the eye is peculiarly liable to diseases due to disease of the blood current, or anything producing disturbance in the circulation of the blood, the peculiar circulation through the eye. Now with reference to these general diseases, hysteria, neurasthenia, and so on, of course these cases are necessarily in the hands of the general practitioner, where they belong, and require their attention, almost entirely. The point of glaucoma which the doctor brings out is certainly one of the most interesting to the general practitioner, as they nearly always see the case first, and if a mistake is made in a case of glaucoma it may be, as the doctor has stated, one of the saddest things that you can remember in your practice. I do not believe that we should make such a mistake, for instance in the use of atropia in the eye. Of course the doctor could not take up the whole field. It is a very common thing for physicians, when patients come with eye pain, to drop atropia in the eye. You don't think of glaucoma, but you simply add to the trouble and place the eye beyond the hope of proper treatment. Another point that the doctor makes, and that is, that acute meningitis develops a good many eye difficulties, which has been brought to my attention where I have had to struggle with such an epidemic. It occasions paralysis of the ocular muscles, and results frequently in permanent locomotor ataxia. Syphilis, too, is responsible for a great many eye troubles, especially muscular troubles of the eye as well as a lot of other disturbances, and locomotor ataxia, as has been suggested, is one of the first symptoms that we come in contact with in connection with eye symptoms; muscles of the eye paralyzed, and pupil contracted sometimes not larger than the sharpened point of a pencil, which is characteristic of cerebrospinal meningitis.

Dr. Magee: I feel under great obligations to Prof. Hotz for this paper. I was particularly pleased with the clear and concise statements which he made in relation to the glaucoma. This ought certainly to be more understood by all of us, no more the oculist than the general practitioner. The Professor has cer-

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tainly done well to arouse our attention to the serious nature of the troubles which he has in mind, and particularly to induce increased attention to glaucoma. The peculiar greenish cast of the pupil that comes on certainly ought to arouse our suspicion to the seriousness of the case, when it comes to our notice. This may arise from mere temporary eye strain, and if so, will pass off after a nights rest. But where it persists after a night's rest, then it demands careful attention. Now, this paper is valuable to the oculist as well as the general practitioner, in showing the importance to the oculist of a knowledge of general medicine. The oculist who endeavors to practice eye surgery without a knowledge of general medicine, generally runs ashore. Take this one instance of glaucoma, which may arise sometimes from one cause and sometimes from another, outside of the eye, sometimes from rheumatism and syphilis, will bring on glaucoma. And again, glaucoma may be brought on purely and simply by eye strain. We should have such knowledge of general medicine as will enable us to recognize the real source of eye troubles, in order to give them proper treatment.

Dr. Boyle: I wish to thank Dr. Hotz for this paper from the standpoint of a general practitioner, Dr. Minney last night stated that a few years ago serious cases were generally sent out of the State, while now, the highest degree of surgical knowledge and skill are to be found right among us; and it is true that the most important operations involving invasion of the great cavities of the body are performed successfully among us. This paper, however, admonishes us, to some extent, of the old saying, "fools rush in where those more learned fear to tread." This paper tends to show that there are some cases which we may not be able to treat, either from lack of skill or lack of experience. We ought to be able to recognize conjunctivitis and other diseases of the eye, as they come to us; we first see these cases, and for the purpose of general practice we can not know too much of the general nature of the eye. In large cities a person may of course go at once to a specialist, but generallly of course he goes to one like ourselves in general practice. Certain cases come up in which it is necessary for the interests of the patient, and for our reputation, to send the patient to an oculist. It is probably well for us to do so in any obscure case where we are in doubt as to our diagnosis. It is advisable in these cases for us to know what to do in these cases on their presentation to us, and it is no less advisable for us to know what to do.

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Dr. Hotz (closing): I thank you very much for the attention you have paid to my paper, and for the satisfaction you have expressed with what I have said. I selected this subject not to preach a sermon to the general practitioner, and have not intended to show that it will always lead to the wrong results if we sometimes work with blinds before our eyes, like the horse. Therefore I did not speak in my paper only of the effect of the eye upon the general nervous conditions, but also of the effect of the general nervous conditions upon the eye, because there is a point where oculists, if they get too narrow minded, make a mistake. I have related to you the blunder of the general physician in not recognizing eye disease caused by glaucoma. I could recite to you also, mistakes that oculists have made. There is in some cases, especially in the younger class, a disposition to be too oculistic, that is to pay too close attention to the eyeball, and forgetting that there is a large portion of the human anatomy outside. If the oculist in every case of deflected eyeball limits his attention to the strabism, he is liable to go the wrong way as much as the physician who does not look into the eye when failing sight indicates glaucoma. In a recent case where the patient's eyes shows converging squint, a young oculist determined to cut the internal rectus muscle, when a very little attention to the history of the case and to other symptoms not connected with the eye, would show that there was some serious brain lesion which was at the bottom of this apparent muscular squint. I again thank you for your attention, and for the manner in which you have received my paper.

Dr. John Punton, Kansas City., Mo, read a paper on "The Diagnosis and treatment of Neurasthenia."

Gentlemen: Last year Dr. Wilhoit, of St George, read a very interesting and instructive paper before this Society on the subject of "Neurasthenia." Among other things he called especial attention to the fact that neurasthenia was one of the most common and general diseases that the general practitioner was called upon to treat, and on account of its obscure nature and character many serious mistakes were often made in its diagnosis and treatment.

I am sure those of you who have had even a limited experience with genuine neurasthenia will fully indorse the statement of

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Dr. Wilhoit, for in my judgment there is no serious affection of the nervous system that is more generally misunderstood by the profession at large than this fatigue neurosis. After istening to the paper of Dr. Wilhoit, I at once decided that I would prepare a paper enlarging upon the diagnosis and treatment of neurasthenia, and, if permitted, present it to this Society, which I now take pleasure in doing. Before alluding to the principles which govern its diagnosis, it is very necessary to possess a clear conception of what the term neurasthenia implies. I shall therefore purposely review the more essential features belonging to its clinical study as demonstrated by those most competent to judge of their relative merits.

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The term neurasthenia was supposed to have been first used by Dr. Beard, in 1889, but it has since been discovered that it can be found in an old Dunglinson dictionary as early as 1833. Prior to Dr. Beard's immortal monograph on the subject, much confusion prevailed in the proper interpretation of a large group of symptoms which were fundamentally dependent upon a morbid weakness of the nerve centers, but which had been previously ascribed to disease of the various visceral organs involved, such as perverted conditions of the heart, lungs, kidney, uterus, liver, stomach, etc. The result of Beard's work, however, led to a more thorough systematic study of its pathogenesis, and the conclusions so far reached warrant the assertion that the term neurasthenia expresses an affection that does not limit itself to any part of the nervous apparatus, but affects it as a whole. Hence, it is an extremely generalized condition affecting the brain, spinal cord, peripheral nerves, the visceral organs, and, indeed, all parts of the human organism subject to nervous innervation. It is also often associated with other functional as well as organic neuroses. Consequently its symptomatology is exceedingly extensive and varied, and it is this wide range of involvement that has led to so much confusion in diagnosis.

In the study of pathology it has been the aim of modern scientific methods to associate symptoms with lesions, as it is largely by such means that we answer the two most important problems in every diagnosis, viz: The seat of the disease, and its nature and character. This scientific method presupposes a thorough knowledge on the part of the physician of the anatomy and physiology of the organs involved, for this, as Dana correctly states, "makes clinical neurology comparatively easy, and, in fact, reduces much of it simply to a matter of logical deduction."

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As symptoms are the expression of some derangement of structure or function it follows, as a logical sequence, that a knowledge of the functions of the nervous system is indispensable to accurate diagnosis. You are already aware that the nervous system is an apparatus composed of a series of mechanisms designed to preside over or control various functions of the body. For convenience they may be arranged into seven classes, viz: The motor, sensory, reflex, trophic secretory, psychical or mental, and the visceral mechanisms. When any one or all of these are involved in any pathologic process they give expression of this violation in the form of symptoms.

The diagnosis of nervous diseases therefore largely hinges upon the physician's ability to properly differentiate or interpret the extent of the impairment of each of these wrought by any lesion. As some of the pathologic agents naturally select certain structures to spend the force of their baleful influence upon, others are non-selective in character, and are therefore more widespread in their destructive powers. In neurasthenia the nervous system suffers as a whole, consequently all its specific functions or mechanisms are impaired to a greater or less degree, varying with each case. This results in a multiplicity of symptoms, which for the most part are of a purely subjective character, and greatly adds to the difficulties of diagnosis. It is to their correct interpretation, however, that we are compelled to depend upon for success in diagnosis.

All authorities agree that the cardinal symptoms of neurasthenia present well marked evidence of weakness and irritability of the nerve centers, which in themselves are expressive of fatigue. Weakness and irritability of the nervous mechanisms that preside over the various bodily organs are therefore the chief clinical phenomena belonging to any and all varieties of neurasthenia. In its quintessence the consensus of opinion by those most competent to judge, declare that neurasthenia is a true fatigue neurosis, characterized by an increased morbid reaction of the ganglionic nerve centers, to all kinds of impressions, both mental and physical, whether slight or profound, producing an excessive nervous weakness, and nervous irritability, which become its leading symptoms. These may properly be regarded as the primary symptoms, and associated with these are all kinds of secondary or adventitious symptoms.

Both classes, however, may affect in varying degrees of intensity the physical and mental constitution of the patient; the

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former predominating in the one, and the latter predominating in the other, while in most cases both elements are combined.

Moreover, the various mechanisms involved in the process vary greatly. For instance, the motor impairment may be so great as to cause the most profound exhaustion on the slightest effort, or this may not be so marked a feature; but the sensory apparatus may be the predominating element, in which case we may have severe neuralgic pains, or the sensations of touch, temperature and muscular sense, as well as the special senses, may present every degree of involvement. The same is true of other mechanisms of the nervous system, so that no two neurasthenic patients are exactly alike in their ailments, and this fact has led to a complicated classification of neurasthenia, which in my judgment only tends to confuse rather than aid the physician in its diagnosis. For instance, different authors classify it according to its etiology, symptomatology, or the apparent seat of lesion. According to this we may have cerebral, spinal, traumatic, sexual, toxemic, reflex, and many other forms of the malady. As a result, no two text-books agree, and the physician who naturally depends upon these aids in such emergencies are sadly disappointed, and feel somewhat disgusted at our apparent inexact methods of diagnosis.

A classification that recognizes neurasthenia in its entirety is to my mind much more preferable, and from this standpoint it can be reduced to two classes, viz.: Complicated and uncomplicated neurasthenia. In the former it may be found associated with many functional, as well as organic diseases, such as epilepsy, syphilis, malaria, gout, lithemia, rheumatism, uterine disease, hypochondria, sexual perversion, and even insanity.

In the latter it presents itself by a conspicuous absence of any of these complications, in which case, it is known as simple neurasthenia. Recent investigations prove conclusively that for its production two conditions are indespensable. I, "A noxious agent, and 2, A relative vulnerability of the organism or of some part of it." (*Patrick.*)

These two etiologic factors vary enormously in different individuals, sometimes the one predominating and sometimes the other, but usually they are more or less combined.

Clinically speaking these causative factors have much to do with the production of symptoms, and as before remarked, upon their correct interpretation hinge the diagnosis.

As neurasthenia is a neurotic functional affection, the first

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principle in its diagnosis is to exclude all organic lesions. While it is true that it may be and often is associated with organic diseases, yet these must always be regarded as complications, and not essential parts of the malady itself. The symptomatology of neurasthenia is therefore of a purely subjective character, and as all organic diseases of the nervous system are attended with a train of symptoms peculiarly their own these can readily be detected or excluded by applying the method of exclusion.

Having excluded all organic diseases of the nervous system, those functional affections which neurasthenia most closely resemble and with which it is extremely liable to be confounded, are hysteria, melancholia, hypochondria, and simulation.

In spite of the popular belief that neurasthenia and hysteria are one and the same there are several important points of difference which aid us in their differential diagnosis. For instance, it will be remembered that in neurasthenia we have no true paralysis, while it often occurs in hysteria. The same is true of anesthesia. This never belongs to neurasthenia only as a complication, while it forms an essential part of the stigmata of hysteria. Again convulsions are common to hysteria while they never belong to neurasthenia only as complication. This is also true of contractions. In addition to these we find the two affections differ in their course and general aspect. As a rule neurasthenia is gradual in onset while hysteria is usually sudden, and the accompanying symptoms, such as the globus hystericus, the concentric visual fields are not so common and persistent in the one as the other.

It must be confessed that the differential diagnosis of incipient melancholia is not always easy. By close observation however the characteristic tripod of symptoms belonging to melancholia, viz.: Marked and persistent mental depression, insomnia, and occipital headache, is not so marked and persistent and often is entirely absent in neurasthenia. Moreover suicidal impulses are common to melancholia not so with neurasthenia.

In hypochondria the ailment is exclusively mental. The mind being occupied with a fixed idea concerning some special bodily ailment which amounts to a true delusion. In spite of this the hypochondriac is able to undertake physical exertions which the neurasthenics cannot begin to do but they are also destitute of the barometric changes from day to day common to neurasthenia.

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It cannot be denied that the physician occasionally meets with a person who is a genuine malingerer. There are also others who suffer from slight bodily ailments implanted upon a neurotic diathesis. Such persons present many symptoms in common with actual neurasthenia. Much experience and good judgment combined with tact is necessary at times to distinguish the real from the counterfeit and occasionally the most skillful diagnostician is deceived by simulators. Observation long continued is the only means of detecting such fraud. The close relation that exists between neurasthenia and insanity must not be overlooked in the diagnosis. One of the most important signs of this is the manner in which the feelings, thoughts and actions of the patient absorb his entire attention. This ultimately forms the basis of morbid fears and doubts or nosophobia. These imperative concepts or fixed ideas often amount to true delusions and later lead to impulsive acts.

Treatment.—If neurasthenia is a true fatigue neurosis resulting in a diminution of all the specific energies of the nervous system, then it follows as a logical sequence that its treatment should embrace measures directed to overcome their special weakness. From this standpoint the measure of leading importance is that of rest.

In many cases to be effectual it should be absolute, and for this purpose the patient is advised to go to bed. Not all patients, however, require absolute rest but it is a safe rule to apply in the majority of cases. This is, however, largely governed by the demands of the case. If the patient is profoundly exhausted on the slightest effort, then it is an absolute necessity. On the other hand if the nervous weakness is not marked it is well to institute a scheme which embodies partial rest. In this case the patient can retire much earlier than is is usual and prolong the hours of rest before rising. The object of rest is to restrict the expenditure of nervous energy. The amount of rest and its duration differs, therefore, with each case, and the skill of the physician lies in knowing when it can safely terminate. To keep certain patients in bed for too long a time means certain failure, not to keep others longer in bed than they wish also means failure. This is a practical age and what the friends of the patient are seeking, if not the patient themselves (for often they care but little what becomes of them) are results, and the physician that can produce results is the one that is usually kept busy.

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Equally as necessary and important is the enforcement of the principle of isolation. Like that of rest, to be effectual it should in most cases be absolute and preferably away from home. There are several good reasons why isolation from home is necessary for the best results. In the first place the conditions of home life in which the affection developed is not favorable to recovery. Quite often it presents the extremes of indulgence and irritability.

Then, again, the prolonged illness of the patient appeals for sympathy not only among the members of the family, but, also, the friends in the entire neighborhood, and no small amount of harm is done by constant interchange of experiences, that finally results in the patient having fears of his own incurability. Having secured the consent of the friends as well as the patient to take the necessary rest, and the removal from home for treatment, you are now prepared to enforce another powerful curative influence, viz., *suggestion*. When this agent is used arightly, it includes all the influences and possibilities of a strong and appropriate personality in both physician and nurse. And just here allow me to remark that a reliable experienced nurse is just as important to the enforcement of the principles already referred to as an experienced physician for all kinds of excuses will be forthcoming to defeat the ends sought after. In its essence suggestion embraces all the potency included in the general term hypnotism for the substance of this is none other than suggestion.

Associated with the term hypnotism, however, there has sprung up a false notion which supposes that it consists of some mysterious element or power known only to those who profess to practice it. This false conception is heightened by the elaborate and mystical ceremonies made use of by the charlatan but when shorn of all its nonsenical paraphernalia it can be used with as much potency in the sick room as when attended with all the gaudy show and flourish of trumpets commonly associated with it.

Its successful practice, however, depends entirely upon the physician's ability to influence the mind of the patient, and the first step in the process is to gain his or her full confidence. In accomplishing this, much tact, ingenuity, and good judgment is sometimes needed, for it requires more skill to play upon the mind than upon the finest piano ever constructed. Not all physicians can use this mighty power of suggestion with success hence

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they conclude it is of no avail and ridicule those who profess to practice it, and claim that it smacks of quackery, but with many it is their most powerful curative agent and the physician who carelessly neglects to apply judiciously this remedial agent is in my judgment not fully equipped with all the curative powers within his reach.

In this connection I desire to emphasize a statement of my friend, Dr. Gray, of New York, referred to in his work on nervous diseases. When he says, "The example of the quacks through all ages has been too much contemned, I think, by the general practitioner of medicine and yet every physician of experience knows of the startling success they occasionally obtain. Nevertheless imposters as they are these men have done with fraudulent intent what the scientist ought to do with an honest purpose, namely, recognize that the human mind is a much more potent instrument to play upon than the nervous system of the stomach and intestines."

Hand in hand with these measures is the application of artificial exercise which includes, massage, electricity, and hydrotherapy. As convalesences advances, light occupation and mental employment must gradually be introduced. For the special uses of each of these and to economize time, I cannot do better than to refer you to the more recent text books on nervous diseases.

Special dieting is also called for in the treatment of neurasthenia which must vary with each case, suffice it to say that milk and eggs form the sheet anchor, to be later supplanted by more substantial articles of diet. In this connection I desire to call especial attention to the value of the use of the *scales* in determining the progress of the case. Very few physicians count the scales as a part of their therapeutic armamentarium, but their value in neurasthenia and allied states cannot be overestimated.

No less important is the removal of any known complication or peripheral irritation. Hence, surgery has its legitimate place in the scientific treatment of neurasthenia.

Much could be said on the surgical aspect of neurasthenia, but I hasten on to conclude with a few brief remarks on the use of drugs in the treatment. Unfortunately, too often the medicinal treatment is made to supercede the non-medicinal, which in my judgment is a great mistake. In the majority of cases, however, both classes of agents are essential for successs but they must go hand in hand, requiring at times a wise discrimination in their use.

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The very nature of the malady suggests such drugs as will favor changes both in the quantity as well as the quality of the constituent of the blood. As these are already known to you, it is unnecessary for me to repeat them here.

For the relief of the pain which is often a troublesome symptom, the use of the coal tar preparations are valuable and for the insomnia which usually accompanies it the judicious use of hypnotics is warranted. No class of cases present themselves to the physician for treatment that require more care and judgment in the use of such agents as the various forms of neurasthenia, and positive harm is frequently done by their indiscriminate use. As the course and progress of neurasthenia varies like a barometer from day to day, the use of drugs must vary to meet its fluctuating tendencies. To sum up the whole matter the treatment of neurasthenia depends for success upon the intelligent application of the principles already referred to such as rest, isolation, suggestion, artificial exercise including massage, electricity, hydrotherapy, mental and physical employment, special diet, the judicious use of drugs and occasionally surgery. If time permitted, I would be glad to cite cases illustrating the successful application of these various agents, but I fear I have already overtaxed your time and patience. My only hope, however, is that the remarks embodied in this paper may prove of some assistance to you when called upon to treat that most troublesome of all affections—neurasthenia.

DISCUSSION.

Dr. Eastman: The doctor's paper is certainly a most interesting one, and it touches the requirements of a paper on neurasthenia with a master's hand. It is one of the most troublesome and difficult of the nervous diseases that we have to treat, and I am fully in accord with the remarks he makes and the lines he lays down in regard to the method of treatment. I agree especially with the importance, not only in neurasthenia, but in all of the other diseases similar in character, of removal of the patient from home. This is of the highest importance in the treatment of these diseases, and no one can do himself justice, or do his patient justice, while they are still at home, in the midst of the conditions that have brought about the difficulty, and in the midst of the suggestions adverse to recovery which occur almost every hour in the day.

Dr. Lindsay: I think the definition given in the writer's paper is a little misleading. While I desire to express my appreciation

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of the paper, the expression "fatigue neurosis" would lead us to believe that we have a normal stock of energy overdrawn upon. That by our over-exercise of the various functions of the brain connected with the nervous system we have brought on this disease of the nervous system. This may be true, but it seems to me the truth lies partly in another line, and that in neurasthenia we have cell weakness and failure of the restorative energy of the brain cells, which makes the effect easy, and which makes it possible that the ordinary efforts of life may bring on this condition. It seems to me that therein is the real disease, that the disorder originates in inherited cell weakness. You take a man or woman of normal build, with normal store of energy, let them go on with the ordinary drafts upon their nerve energy, and it is apparent to all that they will not develop neurasthenia. It seems that instead of calling this "fatigue neurosis" it would be better to call it structural cell weakness in the individual, developed, perhaps, as the result of several generations of wrong living. This is the most apparent in certain races of people, and particularly is it true of the Jewish people who, under their peculiar circumstances, have overdrawn on their nervous energy until they have developed a great deal of this disease. The things the doctor has said about the treatment, and with reference to the various organs, are all good. I think, however, we should keep in mind prominently the simile of the quantity of energy which may be overdrawn by any of these organs, and that it is the small quantity one has to start with that makes it necessary to guard the outlays in these various organs, to avoid overtaxing them and overtaxing the brain centers. These are all openings through which energy escapes to the development of neurasthenia.

Dr. Dannaker: The word "neurasthenia" is a word used to describe a series of symptoms. Dr. Punton, in his paper, went over the ground thoroughly, and his conclusion in regard to rest—absolute rest—is right, removal from home and family environments, and from demoralizing family influences. But there is one thing that I feel impelled to call attention to, and that is the general practitioner should make his diagnosis very cautiously. No one of us who may have a case of neurasthenia wants to make a mistake and diagnose it as insanity. No family wants the stigma of having an insane member. We should endeavor to get at the truth as early as possible, so that we may assure the friends of the patient that it is not insanity. We should have more fre-

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quent recourse to proper instruments in connection with diagnosis. How many are capable of using the ureometer? how many are capable of using the microscope, so as to tell that the kidneys are not the seat of the disease. How many of us know in regard to the presence of urea in the amount that should be secreted, and that it is being properly excreted? It is of great importance to determine that the secretions are properly excreted and not dammed up in the system. Many persons have been sent to asylums as insane, when it has been a case of absolute prostration of the nervous system from overwork, when the family environments have been of an exacting nature, there has been wearing financial obligations, and rest, cathartics, with proper diet, away from family influences, would meet the requirements of treatment. Then, if the urea is not excreted, if it is being dammed up in the system, we have subjective symptoms, and close attention should be given to determine if the kidneys are operating as they should. In many instances, we find purely imaginary symptoms, so that you and I, going to the bedside and sitting down, talking with the patient, taking the pulse and the temperature, asking if the bowels have operated, and so on, we go away knowing no more about neurasthenia than just guess work.

Dr. Sexton: There is a great deal to be said about the diagnosis, and especially about the treatment of neurasthenia, apart from anything that the doctor may have said in his paper, which I did not hear in full. In the treatment of neurasthenia there are two or three things that are of very great importance, and quite likely Dr. Punton has forestalled me in this matter. One is in taking the patient away from the unfavorable environments in which the disease had its origin. I consider that of prime importance. If the family is one in easy circumstances, the patient can go to the sea-shore or to some nearby place, and be in the house of the practitioner, which is desirable, or in some house near that of the practitioner. It is of the utmost importance that the patient should have the utmost confidence in the doctor, and the reason for this lies in the fact that there is no factor that enters more properly into the treatment of neurasthenia than suggestive therapeutics. The physician who undertakes for month after month the curing of this disease with medicines will find how little medicine avails, how much there is in hygiene and in the morale with which he surrounds his patient. Nutrition must be looked after, alimentation must be

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taken care of. Above all things else, I think, the patient must look forward confidently to recovery. I believe that in these cases we are justified in taking a friend of the patient, some responsible friend of the patient, aside and saying "Now I am going to promise rather more than I expect to perform." We all know neurasthenia is a disease that belongs largely in the psychic realm, and it should be treated psychically. Therefore we should avail ourselves of every element that can be brought to bear on the disease, and therefore we should take some friend aside so as to clear ourselves from any charge of hoodwinking the patient, or advising the patient of expectation of recovery when there was no hope whatever, and then we should promise the patient much more than we expect. The treatment of neurasthenia is difficult at best, and wherever we can avail ourselves of personal magnetism, and by promising much and holding out something to the patient to grasp and pull himself out of the mire of this psychic disorder, we should do it.

Dr. D. W. Basham, Neal, Kas., read a paper on "Some Remarks on Hysterectomy."

Hysterectomy has been so frequently and so fully discussed of late that I hesitate greatly to bring the subject before this Society at this important meeting. Nevertheless, I hope to find some justification for calling up this old subject, because of the extensive application of this procedure in the management of various pathologic conditions limited to the organs of the female pelvis. In the beginning the operation was suggested only in the face of the direct exigencies, but as time wore away and the art of surgery became more perfectly developed this major procedure naturally found a wide range of application. The operation has passed through the sombre stages of abuse and misapplication, necessarily attendant upon its vulgarisation, and stands as a well defined chirurgical procedure capable of as beneficent returns as any therapeutic measure at the command of the surgeon.

This operation, at first performed only to rescue the patient from impending death, came by degrees to be employed for the relief of many of the less grave conditions of disease. To enumerate all the different affections for which hysterectomy is employed at this age, would be something difficult. Notwithstanding the fact that hysterectomy may be too frequently employed, it is established beyond refutation that in many of the

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painful conditions where oophorectomy fails completely hysterectomy succeeds perfectly in relieving the symptoms. So well is this known that in dealing with a condition where it is deemed necessary to sacrifice the ovaries it is wise to extirpate the uterus at the same time. In the management of fibroids the operation of hysterectomy is being supplanted by simple myomectomy, but the wisdom of this is extremely doubtful, excepting in a certain few instances of markedly pediculated fibroids.

Anyone who has witnessed the removal of a large number of fibroids by morcellation, cannot have failed to observe how very frequently the operator is able to enucleate small fibroids from the walls of the uterus, the existence of which could not have been recognized without opening up the walls of the organ.

I have many times seen a number of small fibroids thus enucleated from the walls of an uterus in the course of an operation. The fact is, that when an uterus has undergone fibroid metamorphosis, that the entire mural tissue of the organ is generally interspersed with small fibroids, and that consequently it is only in the case of pediculated tumors that myomectomy can conservatively supercede hysterectomy. Otherwise myomectomy ceases to figure as a conservative measure, because it leaves the patient extremely prone to become the subject of another serious operation when the fibroids which were obscured in the walls of the uterus shall have developed into large tumors.

Hysterectomy for malignant degeneration is always a wise procedure, provided the disease is not too far advanced.

Hysterectomy for chronic inflammation of the endometrium with marked hypertrophy of the uterus in a patient approaching the climacterium, may sometimes be perfectly justifiable. These are the women who suffer greatly from pain and hemorrhage while passing through the critical period. Hysterectomy circumvents all this suffering, and is far safer than to be subjected to the frequent depletion of the hæmic fluids and the pain and nervous phenomena attendant upon the constant dragging of the enlarged and weighty uterus upon its attachments.

It is sometimes very difficult to discriminate between the cases that may be relieved by some of the minor procedures and those which must of necessity be subjected to the radical measure. Therefore if an operator make an occasional questionable operation, he should be excused, but the wanton sacrifice of the

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uterus and the consequent wrong inflicted upon the trusting client merits nothing but the severest condemnation.

I beg to say at this juncture that it is just as harmful and equally blameworthy to subject a trusting patient to amputation of the cervix and colpo-perinerrhaphy, when the disease is in the adnexæ as to do an hysterectomy when some less grave procedure might have sufficed. You will pardon me the mention of this, when I say that less than two years ago I saw an hysterectomy done by one of the most distinguished gentlemen in the profession, for the removal of two large sausage-like tubes from a patient on whom an amputation of the cervix had been performed by an equally distinguished surgeon, some two months before.

Hysterectomy for procedentia uteri is sometimes necessary. The operation when done for prolapsus, has not always been satisfactory. In my own experience, however, good results have been obtained from the treatment of prolapsus by hysterectomy, but in order to succeed care must be taken in the disposal of the broad ligaments and vaginal wound in such a manner that the vault of the vagina shall be supported by the broad ligament stump and the patient must keep the bed six or eight weeks.

During the long course of time required for the development of the manual technique of the operation, the procedure was subjected to various mutations. Thus it happened that toward the close of the experimental stage that the operation was performed sometimes through the vagina and sometimes through an abdominal incision. Later still, the advocates of the method per vaginam became divided on the subject of hemostasis, the Germans employing the ligature for the broad ligaments and closing the vaginal vault, while the French were employing the hemostatic clamp and allowing the vaginal vault to remain uncared for, save the introduction of some gauze for drainage, and to prevent erosion of the intestines through contact with the ends of the forceps resting in the vagina. Still again, operators who were trusting exclusively to the hemostatic forcep to control the arteries, became divided upon the subject of preliminary or provisional hemostasis. So, today, the clamp operation is often performed without any form of hemostasis whatsoever until after the uterus has been delivered at the vulvæ, at which time the clamp is applied from above downward.

Lately, hysterectomy has often been done without the aid of either clamp or ligature, and this without any reference to the

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Pratt method. Professor Tuffier has done a number of successful operations during the past year, in which hemostasis was secured by angiotripsie, performed by means of an instrument denominated the angiotribe. This is the nearest approach to an ideal means of securing hemostasis in these operations, because there results but little, if indeed any, more necrosis from the process of angiotripsie than follows the use of the forceps or the silken ligature. The wound may then be dressed at the close of the operation and left undisturbed for six or eight days.

The operation through an abdominal incision has likewise undergone various changes in the matter of operative technique to be brought at last to a degree of perfection little short of the absolute. Until a few years ago, the methods of doing abdominal hysterectomy were so very crude and manifestly unsafe that the operation was held in great disfavor. The extraperitoneal method of handling the stump was the only method possible in the early history of the operation, because of the crude and undeveloped notions concerning surgical technique.

Now that the technique of the two operations has been developed to such a high degree of perfection, and that the death rate from the procedure, whether done through the abdomen or through the vagina, differs but little, it is left for the operator to discriminate in each particular case, as to which method shall be adopted. Whether one is able to work better through the vagina or through a supra-pubic incision seems to be a subject of dissension between the gynecologists of today.

Now, as a matter of fact, plain enough to the unprejudiced observer and worker in this field, there exist cases which are amenable to the vaginal method and which should not be subject to the opposite method upon any excuse, and vice versa, there are cases which should be treated only by the abdominal incision. To know when to do celiotomy and when to do the vaginal operation is the duty of the operator in the field today. To continue practicing celiotomy on all cases to the absolute exclusion of the method per vaginam, or always to do vaginal hysterectomy to the utter exclusion of the supra pubic method, is simply to continue to put in force the logic of Dr. Sangrado of le Sage's Gil Blas. The general idea is that in the character of Sangrado, Le Sage intended only to ridicule the practice of phlebotomy, but such was not his idea. It will be very clear to him who will take the pains to examine carefully the text of Gil Blas, that LeSage was only ridiculing the doctors of his time over the shoulders of

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Sangrado for applying the same remedies alike to every case, whether it were a case of rheumatism, gravel or pneumonia or something else. In this, which is the true sense, I am pained to acknowledge that the family of Sangrado is not yet wholly extinct, even in our most progressive land.

In conclusion, this paper urges that beginners seek to become adept in all recognized methods and practice them each upon the individual cases to which they are applicable. By thus acting, the death rate will be greatly diminished, because when a case is subjected to the most convenient and appropriate treatment, the chances of recovery and permanent cure are immeasureably enhanced.

As to the manual technique of the operation, I believe that the methods followed in Europe for the vaginal operations, are superior to our own, excepting in the cases of a limited number of American operators. Doyen has given us, perhaps, the most perfect rules for doing hysterectomy through the vagina. I believe the supra pubic operation for hysterectomy is better developed in our own country than elsewhere.

DISCUSSION.

Dr. Ward: I enjoyed the paper very much, but I do not understand that the doctor makes any point that he especially desires discussed. The doctor apparently does not recommend one operation in preference to another, but personally I think it is a very large operation. There are so many possible complications in hysterectomy of any kind or character, one must be a well-rounded abdominal surgeon, a good practitioner, and a sound-minded man to undertake operations of this character. I think when we go into the pelvis and remove the appendages to the most important organs of the human body, we ought to know how we are going to leave our patients. Are they going to be better or worse off than before. If they have malignant disease, and it has spread to other parts, I think we will do better to leave the organ in place than to invade the cavity for its removal. I have had instances in my own practice where hysterectomy has been had in comtemplation, and I have found the disease so far advanced that I have sent the patient home to die, but she did not die. It is important it all cases to be certain that the growth of the disease is confined to the cervical portion of the uterus. If the patient is a young woman I would not recommend the operation, but in the case of an elderly woman I see

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no reason why it should not be done. In regard to details, I have not in my own practice found any use at all for the clamp, except where it is apparently impossible to control the bleeding without it. The more I do this work the less use I have for ligatures and the less use for clamps. I believe the time has come when it is crude to resort to the clamp. If I was a woman, and a doctor used a clamp in performing this operation upon me, I would haunt him the rest of my life if I lived through it. I do not see why a patient should not go home in two weeks after this operation as well as two months. I think hysterectomy has a place in surgery second to no other operation. Very frequently the removal of the appendages relieves suffering and prolongs life. If we do not remove the appendages vaginal troubles will arise, nervous diseases, etc. But the operation should not be resorted to in the case of a young woman unless there is a very grave necessity for it. The uterus is an organ the woman is entitled to, and she should be allowed to retain it as long as possible. But when it becomes diseased beyond relief, and great suffering is entailed, it must be removed. But do not use the clamp if you can help it.

Dr. Cordier: In most respects I agree with what was said in the paper, but I must express my dissent from the remarks of the gentleman who has preceded me, in regard to the disuse of the clamp. I have used the forceps in most of my own cases, and so far I have been very well satisfied. In many cases where the disease is malignant I have been unable to get into the tissues safely to a sufficient extent to warrant dependence upon ligatures. You can not apply the ligature in all cases.

Dr. Sheldon: I like the clamp. I like its action, and I like the results afterwards. I have never yet had a vaginal hernia, or anything of the kind resulting from the use of the clamp. I do not always use the clamp, use ligatures sometimes. We can often do a complete enucleation without using any hemostat.

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Dr. M. P. Sexton, Kansas City, Mo., read a paper on "The Treatment of Inebriety and Drug Addictions."

There are a few morbid conditions which the family physician feels his inability to satisfactorily treat and the sufferers from these are doubly unfortunate. For one thing the patients are not treated with the same vigor and persistency which they would be if the doctor was confident of success; and again, for the very reason mentioned, such cases are often driven to pretentious quacks and charlatans who are quick to find and work such fallow fields.

I shall not undertake in this brief paper to enlighten this Society by unfolding new and startling methods for the treatment of inebriety and drug addictions whereby patients so afflicted may be permanently cured in a few days. Although I have spent many years in this work I have failed to discover any such marvelous remedies. After careful study, painstaking research and considerable experience I am willing to go on record as having failed to learn of any specific. I do not know of any drug that is of value in these conditions which is not known to the profession. I have never heard of a great discovery along this line which did not finally prove to be more or less of a failure. I do not consider it rational to expect that there is in existence or to be discovered some drug or substance which may be introduced into the organism and there counteract the noxious effects of other and toxic substances which have been, may now or shall at some subsequent time be introduced into the same organism. Nor do I believe it rational to expect that any such remedies shall destroy inherited or acquired appetites or propensities. If such things were possible we might also with equal propriety, begin to search for remedies which would destroy the capability of crime and thus rid the race of all its evils by material means. But there is no such panacea for any habit or any lust of body or mind.

Pessimistic as the above statements may seem, it is not necessary that we should despair nor is it proper that we should abandon our efforts to save the victims of alcoholic and drug addictions. Many of them can be permanently cured and nearly all of them can be restored for a length of time sufficient to make it worth while for us to exert ourselves to the utmost in their behalf. Not by hocus-pocus nor prayers nor the laying on of hands, nor yet by the alleged injection of precious metals into the circulating fluid. Not by secret nostrums nor by false

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representations of irregular practitioners whose pretensions would burst like a bubble if pierced by the pin of truth.

But we can best serve such patients by taking them away from home where sympathizing friends might be induced to yield to their entreaties and frustrate our plans. They should be placed under strict surveillance and under institutional regime. Their confidence should be won and their co-operation secured. Their habits should be broken under such circumstances and by such methods as to entail the very minimum of suffering. Every possible therapeutical resource should be resorted to, both pharmaceutical and suggestive, to mitigate the patient's sufferings. And after all has been done that can be done and the habit has been broken, the patient should still be kept in a safe haven until the physical and the moral fibre have been strengthened to the fullest possible extent.

In these matters, as in all others, let us be frank and loyal to our patients and to each other and mercilessly just to quacks and frauds.

DISCUSSION.

Dr. Dannaker: What Dr. Sexton has said, gentlemen, in regard to the somewhat popular methods of curing inebriety and kindred addictions, that there is no hocus pocus about curing such diseases, is absolutely true. There has been a wave passing over our country that we have all met within the past, in regard to the hypodermic method of treatment. We knew, as regular practitioners, that there would be an end to it. We know that if an attending physician can not cultivate the moral fiber in one seeking relief in such cases, the patient is a doomed individual. We know men who are connected with hospitals, and we know what we are talking about. You can not counteract that habit at home. A patient must be surrounded with proper influences, regularity of diet must be assured, and should have a trained nurse at the bedside to effectually prevent breaking over rules and regulations. You must cultivate the highest moral tone of the man, which is lying dormant within him. His secretions are all out of order, he is a physical wreck, the mental make up of the man is completely warped, and there is no way that the general practitioner can hold out hope, nor can the specialist, to the wife, the children or to the man himself, but in proper environment where he will be guarded against himself. You may not have the opportunity in the country that we have in the city, of seeing the internal fabric of an individual break-

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ing down behind the curtain, as we might term it. In this great State of Kansas you have the aid of prohibition to keep out temptation. But in the immediate neighborhood of Twelfth and Grand avenue we have I suppose fifty saloons, and I might talk all day but the saloons would make more money than the doctors. In our hospitals we have many wrecks that wine, whisky and women have brought to us, and if a man has not the moral fiber to stand up and co-operate with us he is a goner.

Dr. Bryan: I want to say a word in confirmation of what the doctor has stated. I have had an experience along the line myself, without knowing that others had reached the same conclusion. If there is not an element in the man himself to save him, all the hypodermics in the universe will not save him.

Dr. Schenck: At the beginning of the so-called gold cure I prophesied that it would run its course in a short time. It took a little longer time than I thought it would. But over against all such methods may be written certainty of failure. They have succeeded only when the patient has been sustained afterward by moral force. "I can, and by the grace of God I will," is the only medicine that will cure us of moral defilement, mental defilement, of the weakness that is associated with the alcoholic habit. Sustain the resolution of the patient by such moral and mental influences and surroundings as it is possible to provide, so that his environment is as pure as possible, and give him such physical nourishment as will sustain his organism, but do not get him to think that he is cured after so many shots, or dopes. He is never cured until he has passed the pearly gates. He wants to keep out of the way of temptation, and his friends want to sustain him in every possible way in right doing and right thinking. Without proper sustaining, without keeping out of the way of temptation, or keeping temptation out of his way, in ninety-nine times out of a hundred, like the sow that was washed, he will go back to the wallow. Do not teach your victims of intoxicants that he is cured, but teach him that he must watch and pray whilst life lasts, and watching and praying, sustained by proper environments and such medication as the nervous system demands, is the only rational cure that I know of for intemperance.

Dr. Sexton (closing): Brief as this discussion has been, I am gratified, and I may say I am somewhat surprised as well as gratified, to know that the views enunciated in my short paper are indorsed by this Society. When I have read some of the flaming advertisements that have been scattered broadcast over this

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country, including the names of eminent members of our profession advocating the use of nostrums, I have felt as though I stood alone. I have sometimes felt that in assuming the position that that I did, that there was no specific for the correction of these habits, that I did not have with me so large a proportion of my fellow practitioners. But I am pleased that no word has been said here to controvert my position. As has been said, it is after all the moral fiber that makes the man. We all know how indulgence in these habits destroys that fiber. Many times we do not fully apprehend how weak the fiber was to begin with. Then when these habits had been fully fixed in a patient, and with moral fibers so weakened, there was very little for us to work on. We know well the after effects of narcotics upon the system. We can not by the injection of material substances into the blood of a patient change that moral fiber. We may, as has suggested, benefit the patient to some extent by a course of suggestive therapeutics, though the effect will be only temporary. As Dr. Schenck has said, the cure is never completed, but the victim must ever struggle against weakness until he has passed the portal of this life.

I do hope the medical profession has got back onto good solid stable ground on this point. I do hope we will cease to support by our patronage those who thrive upon these secret methods of cure, whose hands are against us as ours must ever be against them. Let us be loyal to ourselves as well as to our patients.

THE PRESIDENT'S ADDRESS.

The highest honor this distinguished body can confer on one of its members is its presidency. Without enumerating my long list of disqualifying attributes, I humbly thank you for the exalted distinction.

Since we met one year ago much has happened on the earth, and much that physicians have been more or less connected with.

You will remember that it was just one year ago last Monday that the old man of the sea thrilled the civilized world with his achievements in Manila Bay. In one day he made glory enough to encircle the globe. He made a page in the history of freedom that will blaze for generations yet to come.

Each subordinate officer and common sailor did his duty as well as Dewey. Had they not, the glory of the Asiatic squadron would have remained unrecorded.

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Since we met a year ago internal discord has given way to harmony, sectional feeling has been soothed and every hamlet north. south, east and west has given something dear as life itself to the cause of humanity.

The Kansas boy in the Philippine rice swamps is claimed by Missouri as her own child. It is generally accepted as proven that Hobson was born in Kansas, and did not Schley and Sampson each receive his naval training on the Delaware bar at Leavenworth?

We all know that Fred Funston belongs to Kansas and attended school somewhere near Leavenworth.

Whenever it becomes necessary to "take up the white man's burden" you will find in Kansas whole regiments of Funstons, and not one of them that would hesitate a moment to swim the Pasig or Rio Grande.

If duty, in the name of humanity said do so they would chip the fire clay from the lid of the seething caldron of Hades and dive for the par-boiled heathen. With all our political and military turmoil the progress of medical and sanitary science has not been stayed.

After all, when we take a retrospective view of these "savage wars of peace" we see when the smoke of battle clears away a bit, it was the physician that stood between the soldier and death's troopers which came swarming up from the valleys and jungles. There is something in the clanging steel of uniformed hosts that lends luster to deeds done in battle and the best that can be said of any soldier is that "he did his duty."

I look to-day into the faces of the best representatives of a great army, and I know you have done your duty. You have since last we met been fighting all the time and you have fought unflinchingly in an unequal battle, and without blare of trumpet or streaming banner each of you has waded the swamp, charged the jungle and kept a psychic eye on the foe day and night.

There are few problems in human affairs but have a medical aspect. The great events in life, birth, marriage and death come nearer to us than any other class of citizens.

You may sooth the pillow of senile dissolution, you may steep in the urn of forgetfulness the pangs of parturition. You may assuage the grief of the young mother when tube roses and little coffin lid make the whole world seem dark. You come in contact with all social, scientific, civic and religous problems.

There is a physical morality that Huxley speaks of in his latest

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work on education that you physicians teach continually to the community. Besides treating sick people honestly daily, nightly and unrequitedly, there is much else that the physician can do. He can occasionally rise above the routine drudgery of practice and do much in the community by preventing diseases which he can not cure.

It does not pay the physician as well but it is better for the people; and after all it is the dear people that we are working for.

The physician can not make laws (in Kansas at least) beyond the intelligence of the legislature, and in Kansas the average intelligence of her citizens is not often over-awed by the inscrutable wisdom of her legislators. Every county in the State has a teachers' institute whose members are intelligent and progressive men and women in whose hands rest the destinies of our people, young men and women whose brains are capable of grasping scientific sanitary truths, and whose integrity and zeal will carry these truths to every home in Kansas that is blessed with children of a school age. These teachers can do more to bring about lasting sanitary reform than all the medical politicians that can lobby a legislature.

You can never legislate beyond the intelligence of the masses in a country like ours. A fountain cannot rise above its source.

Needed legislation in Kansas will never come until some of our physicians are born anew, and they must be born with a sanitary conscience.

I believe that a diploma should not carry with it a license to practice medicine, but the practice privilege should be vested in a State examining board.

Our national government takes great interest in agriculture, agricultural colleges and live stock. The congressional act, making appropriations for the United States Department of Agriculture for the fiscal year ending 1898, was $3,182,902. For the year 1899, it was $288,800 more. The largest increase in appropriation was for microscopically inspecting meat to go abroad; the increase being from $675,000 to $900,000.

$37,500 was appropriated for printing 75,000 copies of a work known as the special report on diseases of the horse.

The cost of inspecting southern cattle for transportation last year, was $101,210.55. $720,000 was appropriated last year for agricultural experiment stations.

The expense for telephone during the year amounted to $159,357.

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These are only a few of the expense items; and I ask in the name of all the suffering that comes from filth diseases that our delegates to the National Association work to their best ability towards procuring a National Sanitary Bureau.

Before Mrs. Lease went to New York and ascended to the astral plane of Theosophy, and while yet she was one of us, there was a howling demand in Kansas for less corn and more hell.

One would think from the money expended for agriculture, as contrasted with the meagre $2,150 in this State for public health that what Kansas really needs now is more hogs and fewer children.

The growing evil among our profession of advertising quack nostrums, under this disguise of literary effort, should be discouraged.

The effort generally has some catchy title that arrests the attention such as a "remarkable cure" for this or that ailment or "a clinical lecture by Prof. Drake" etc., etc. These men are doubly dangerous because they belong to all the medical societies, read papers, talk well, often hold a professorship in some kind of a medical college and have their reports, reprints or lectures distributed by the thousands among the honest but too credulous practitioners.

There is a strong suspicion that many of these physicians have much leisure and some invisible means of support other than the work of love.

The best energies of the individual members at this Association should be used to discourage illiterate young men and women who are ambitious of obtaining a medical diploma. The cheap inducement of medical colleges that prepare a diploma "while you wait" should be opposed by the profession to the end that we may cherish an exalted ideal of medical learning.

Young men often drop out of school while yet in the grades and often quit because of their size and stupidity. They loaf for a year or so and then the father goes to the family physician and says he believes his son would like to study medicine; you know the result. This encouragement given by the physician often reflects no credit to the profession and prevents the boy from filling some useful vocation.

The amendment proposed changing the place of meeting for this Society at each annual meeting in my opinion will increase our ability to carry out Article 2 of our constitution which says: "The object of this Society shall be the advancement of medical knowledge, the elevation of the medical profession, and the promotion of all measures adapted to the relief of suffering, the improvement of health and the protection of lives of the community."

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Dr. A. W. Carson, Dover, Kas., read a paper on, "An Obstetric Case With Some Very Strange Conditions."

The causes which lead up to ascites in consulting our best authors one would at once decide are very numerous. The etiology of the disease is various, and many organs have been charged with the promoting causes. We are taught in this age to look for germs as the chief instigators of human ills. But late authority tells us that the germs causing this condition of things are as yet unknown; that the anatomist's scalpel and the observing pathologist with his microscope has as yet failed to fathom the mystery. Let us hope that by patient industry this problem may yet be solved.

With these few preliminary remarks will procede to report case. The case I wish to present to this association is a congenital one. It is so much out of the ordinary that it might be called remarkable. It can hardly be called a monster or monstrosity. I was hurriedly called to attend Mrs. L. in her fourth labor on the morning of December 18th, 1898. Having been with patient in other labors, I felt quite well acquainted with her general condition at such times. On enquiry the lady stated that she thought herself to be in labor though she was only in the seventh month of her gestation. She told me she "missed" May 4th, and upon that date ought to have been confined February 8th, 1899. After trying the effects of morphia to quiet her, the pains continuing, I made a digital examination. The cervix was dilated to about the size of a silver dollar coin, soft and dilatable. Amnionic fluid was escaping in quite large quantities at each pain. I found, what I afterwards ascertained, a K. O. anterior presentation. I waited some time before making the second examination. I was much puzzled to know what was really presenting. The os being fully dilated upon deep pressure, I could feel the bony formation of the head; but what caused the extensive conjestion of the presenting parts was a mystery to me. The scalp under my examining finger pitted wherever I made pressure. After several strong expulsive pains the head was expelled. I passed my finger around the neck of the child, presuming the cord might be the source of the trouble but failed to find it. I then rendered the necessary assistance at the next pain to deliver the body of the fœtus. It was followed by a large quantity of fluid which saturated the bedding and mother's clothing. Imagine my surprise when I viewed the product of this conception. It

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made a few ineffectual efforts at respiration and expired. The head was deeply conjested. The cord was small and had broken off close to the placenta. It was wound around the neck once in a deep sulcus which was the reason my examining fingers did not detect it at the time the head was born. The balance of the body was of a waxy whiteness, it pitting upon pressure in every part. On palpation and percussion I found that the abdomen contained fluid, and doubtless the thorax did also. Should have satisfied myself upon this point, but did not have my trochar at hand. The cellular tissue was so full of fluid that it had a hard feeling and dilated the body of child until it was large as at full term. On account of the prejudice of parents could not obtain a post-mortem. There were no deformities that I could observe.

The placenta was soon expelled by Crede's method. It was almost or quite twice the normal size, very friable and of a greasy feeling when a portion was rubbed between my thumb and fingers. The mother's toilet was carefully attended to, and she made an uneventful recovery. The father and mother are both healthy. There are no constitutional or hereditary diseases upon either side of the families. I can understand how fatty degeneration may destroy the placenta, and thus bring on labor, but what caused the extensive anasarcous condition of the whole body of the fœtus is something I never saw explained in any of my books of reference. In fact, I never read of a paralell case. I have tried faithfully to present this case for your information and consideration and now leave its farther discussion with you.

Dr. R. S. Dinsmore, Troy, Kas., read a paper on "An Intrauterine Compound Fracture of Both Tibia and Fibula."

Mr. President and members of the Kansas Medical Society: I beg leave to report the following case which in my opinion is of sufficient rarity and interest to justify its report at this meeting. About two months ago I was called to see a child two days old which had suffered an intrauterine compound fracture of both tibia and fibula of the right leg about two and a half inches below the knee. There was a well marked cicatrix about the size of a silver quarter, at the site of fracture over the upper fragment of each bone. There was a lateral displacement of lower fragments of about two inches which accounted for non-union. The ends of each fragment of bone had healed perfectly. There was

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no swelling or enlargement, no spurious callous; not painful on motion. There was a well marked varus of the same foot. The knee joint was normal. My first impression was that there was a probable lack of development with failure of union of epiphyses but the seat of fracture was below this point, the fracture was almost transverse, the upper fragment of fibula being almost one half inch longer than upper fragment of tibia. A careful perusal[1] of all the literature on the subject of intrauterine fracture to which I have access fails to discover the narrative of such a case as the one above described. How an intrauterine fracture, with the bones so soft and pliable, with an inflicting force, necessarily so inadequate, could be produced I cannot explain, unless it was from temporary malposition with violent uterine contraction.

Dr. P. D. Hughes, Kansas City, Kansas, read a paper on "Sarcoma of Uterus, Involving Broad Ligaments, Mesentery, Intestine, Omentum and Adominal Wall, Including Rectus Muscles and Skin, Excision.—Recovery.

Mrs. Z., aged 30 years, married, mother of one child, with history of good health up to winter of 1893-4 when she noticed a lump in abdomen, low down on right side. This did not increase very fast until two years afterward, when she did some heavy lifting. Rapid increase in size, pain and tenderness on pressure, and increasing disability induced her to seek relief by operation, in August, 1897.

After the surgical operation she discovered that the tumor mass was still present. She was informed that a cystic tumor of the ovary had been removed, that she was pregnant and that the lump was the womb.

After her return home the mass was gradually pushed much farther to the left by the constantly enlarging uterus.

In due course of time she was confined at term. The child still lives. The lump then returned to the median line. There was no particular pain during the next few months. She then found that she was sick at the stomach upon taking food but did not vomit. Debility increased and she began to feel large and tight. The abdomen became very large and painful after September, 1898.

She entered the Bethany Hospital about the first of the year. Upon examination, the abdomen was found to be very prominent in the median line, rather more full on the left side. A very large

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tumor mass was found, which reached from within the pelvis nearly to ensiform cartilage, hard, but not that marked induration common to the more dense fibroids. The skin above and below the umbilicus was involved, there being several nodules in this region about the size of one's finger nail. The line of incision made in 1897 with the marks of suture, about five inches vertically, plainly visible. The tumor masses in the skin were not keloid but sarcomatous nodules. One or two were rather soft in the middle. The tumor within the abdomen could not be moved without the skin going with it. I could find no motion in the pelvic portion.

Diagnosis: Sarcoma of uterus, disease following line of adhesions into skin, with possibly involvement of intestines by adhesions or otherwise.

Upon stating to the patient and her husband that there was no hope of recovery without operation, and but little chance with one, probably one in several hundred, they earnestly requested me to operate.

Assisted by Drs. C. M. Stemen, J. L. B. Eagar and E. M. Hetherington, Dr. Wm. E. Stemen in charge of the anesthetic, the operation for removal was done on January 19.

An incision was made over the outer margin of the recti, merging a short distance above the umbilicus and close to the pubis, cutting inward and outward, leaving a mere shred of the rectus abdominus on one side and nearly one-half on the other, for a short distance removing the muscle entirely.

I succeeded in entering the cavity well to the right of the tumor mass. The incision was continued downward and upward, always keeping away from the growth, one to one and one-half inches.

At the upper portion the ligations extended across the omentum which was firmly incorporated with the peritoneum and tumor. A portion of the digestive tract was found to be a part of the tumor. We thought it to be the stomach; it was very difficult to identify all that presented, distorted and bound to such a large, fleshy mass.

Upon cutting into this area an inch or so from the indurated portion, we knew by the lumen of the cavity incised that we had a coil of the small intestine. A portion of the mesentery about three or four fingers breadth had to be removed with the bowel. The omentum was almost every bit involved.

After whip-stitching the cut wedge-shaped surface of the mes-

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entery, a large Murphy button was applied. The parietal peritoneum for a space of two or three inches, each way from the median line, had to be sacrificed.

After severing connection between the tumor and the parts mentioned, for, of course, the tumor was not cut into at any point, it was then possible to rock the mass from side to side sufficiently to get at a limited portion of the broad ligaments for ligation.

The tumor had grown into the layers of the broad ligaments so that we found it slow work placing ligatures sufficiently secure to risk cutting away. When sufficiently freed upon each side to get a neck which was composed of the lower segment of the broad ligaments and a very short piece of the cervix which was not involved, several of those present urged me to terminate the operation as rapidly as possible, the patient having been pronounced dead two or three times

What remained of the stump was constricted by wire and rubber ligature and the mass cut free.

During the latter half of the operation, a large quantity of normal saline solution, at a temperature of 110 to 120, was used to flush the peritoneal surfaces. This was repeated several times and seemed to revive the patient's flagging heart. Strychnine was injected freely; Dr. Stemen said to the extent of over ½ of a grain. Also several doses of digitaline, 1-60 grain each, and whisky 1½ ounces.

Great difficulty was experienced in closing the wall. Rubber tissue was spread in two or more places where the peritoneum was entirely gone. Pieces as broad as the hand were used, spread smoothly over the bowels, one end gathered and made to appear externally.

I did this to modify the character of adhesions anteriorly, to assist in the prevention of immediate hernia through so inadequate a wall, and also to assist drainage.

Rubber tissue, flat or folded upon itself many times, is an excellent means of drainage and gives less liability to delayed union. This material was pulled upon two or three times a day after the first day, moving it a little each time, entirely removing it on the third day.

A large quantity of serum was discharged into the dressings. Immediately about and below the stump over the bladder, iodoform gauze was well packed which was changed frequently. The elastic ligature was removed on the second day.

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The wire constrictor was tightened every few hours and removed on the third day. Iodoform powder was freely applied to stump until healing was complete.

The sloughing stump was small. No pus formed at any time. Saline solution, also whisky and milk and eggs were injected into the rectum every three or four hours, for many days.

Strychnine 1-40, and digitaline 1-100 was injected three or four hours apart for about twelve days. Less frequently, of course, after the pulse became better, which took place in about ten days.

There was distress with the stomach for two or three days. A small quantity of cracked ice was given after thirty-six hours. A little tea and toast was given on the seventh day, which was retained.

There was almost entire absence of pain; an uninterrupted convalescence. Dr. J. L. B. Eager kindly examined the specimen furnished him and he reported sarcoma.

The patient had the most devoted attention by intelligent, well trained nurses.

The patient's pulse before operation was 142. It varied from 132 to 142 for many weeks before operation.

She went home with a pulse of 80 when walking about. She left for home March 21st, possibly well.

I am indebted to Dr. Katharine Richardson, Dr. S. A. Roberts, and others for assistance in this case.

DISCUSSION.

Dr. Cordier: I appreciate very much, Mr. President, being called upon to discuss this paper, which, however, I have not had the opportunity to hear perfectly. Looking at the title of the paper, and judging from the extensive operations that the doctor performed, he is certainly entitled to a great deal of credit. With the highest degree of skill possible, the mortality is extremely high in these cases. Not having heard the paper fully, as I have said, I would not condemn the doctor's treatment, but as a rule, where you find a sarcoma so extensively involving other tissues of the abdomen and omentum I question the propriety of removing the growth or attempting such a removal. They return, and they return quickly. If the growth is in an isolated locality, and has not contracted numerous adhesions to surrounding tissues, then an early and complete removal may be followed by recovery.

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Dr. Hughes: I would like to ask the doctor what experience he has had with the use of rubber tissue in preventing adhesions.

Dr. Cordier: I have used the rubber tissue in some cases, more with the idea of preventing adherence of the gauze that I have used for drainage. I think the intestines can not become adherent as long as the tissue remains, but adhesion sometimes occurs afterward, to the denuded surface. If the doctor could have performed a subsequent operation, and slipped a small portion of the peritoneum down from another place, and then closed up the opening, I think it might have been successful. There is some probability that the patient may die within a year or eighteen months, but the doctor has undoubtedly given relief and extension of life, and that is one of the great objects of surgery.

Dr. Hughes (closing): Dr. Cordier gives the patient eighteen months, but I may say that we operated in one case over two years ago, so I cannot accept his confident prediction of death in these cases unless there is complication arising from adhesion.

Dr. L. L. Uhls, Paola, Kansas, read a paper on "Treatment of Insanity in General Practice."

I am aware that it will be hard to interest you with this subject from the fact that most general practitioners do but little work in this line. Insane patients are hurried off to asylums more than ever before, and this practice will continue and even grow, from the fact that we have learned that the sooner an insane patient can be placed under the routine of hospital rules, the better the prospect of recovery. And yet it is well for us to know all we can on this subject, for once in a while we will be called upon to prescribe for these unfortunate patients and we do not want to be called ignorant on this subject. There are at present about 2,500 insane people in our State; there are about 2,000 of them in our asylums, so that leaves about 500 for us to treat in general practice. They are scattered all over the State, and any of us may be called to prescribe for one of them at any time, so that possibly it will be profitable for us to devote a few minutes to this subject at this time.

There are so many varieties of insanity that it would be wise at this time to speak of but a few of them. It is unfortunate that we have no universally accepted classification, and that while many writers are given to criticizing those who are adding

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to the list, they are themselves quite willing to add a new one now and then. I will speak only of those forms which I think we will have most to do with in general practice, viz., Monomania or Paranoia, Mania, Melancholia, Paresis, Dementia, and Epileptic Insanity.

Monomania or Paranoia.—Monomania or paranoia evidently belongs to the class of chronic insanity, from the fact that there does not appear to be a marked or even a perceptible acute stage. I might say here that while there is no fixed rule for saying just when a given case may be called chronic, yet custom has decided that a case lasting more than a year, shall be called chronic. There is in monomania, always a history of mental or moral degeneration and a gradual change in the character, affections, and passions, and sooner or later, there are clearly defined delusions, which influence the life of the patient. As usual here, we nearly always have an inherited predisposition to insanity or it may be an unstable mental diathesis out of which the disorder grows. In very many of these cases these patients are the offspring of neurotic or intemperate parents. They are eccentric, indolent, reserved, suspicious, conceited and vain. They dress strangely, and their main desire seems to be to attract attention. Their egotism is intense. As a case progresses fixed delusions appear. The individual places a high estimate upon his capabilities, and desires to assume power and control. He is often a self-constituted reformer, and just here the trouble begins. He often thinks it necessary to do some act of violence in order to get rid of some one who is in the way of reform. And while we can't say much about the treatment in these cases, just here is where the doctor will probably be called on for advice, and it would be well for him to know that the best course for him to pursue is to look well after the general health and as soon as his patient becomes a nuisance, and dangerous, the doctor will be called on to tell the friends what to do, and his word will probably be taken and acted upon. We may as well prepare for the inevitable. Your patient will go from bad to worse, and should be taken to an institution where he can be subjected to discipline and made comfortable. Treatment is always unsatisfactory. The delusion will last to the end and constantly grow worse. He will die insane.

Mania.—Mania is that condition characterized by an abnormal exaltation and activity of the mental functions, *i. e.*: The intellectual faculties, the emotions, and the will, and shows itself by irrational talking and acting; by delusion, illusion and hallu-

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cination, and by unusual muscular activity. When the friends of the unfortunate victim of mania find out his real condition they will usually hurry him off to an asylum so quickly that the family physician will not get a chance to see much of the case. While these are not always the most unpromising cases, and, in fact, usually they are not, yet they are the ones that excite the most apprehension on the part of the friends, and they will be hurried away. When you *are* called to see such a case, get as much of the history as possible with respect to his former intelligence, his every day life, his accustomed occupation, his family, his normal and usual manner of acting, and whether or not there is a hereditary history. In acute and sub-acute mania, there is usually a history of physical or mental overwork, or both, carried on without sufficient rest, and often there is a history of reverses or possibly successes, or a profound moral shock, which may be caused by loss of property or friends, from disappointment, from the exhaustion attending the puerperal condition or alcoholic or sexual excesses, all of which operate directly or indirectly to impair the the normal standard of health, or cause loss of sleep, and to produce a functional irritability of the brain.

Not often will you meet with a case of mania that has not been preceded by some symptom of depression, and as a rule this form of mental disease does not come "all at once," as we so often hear, for there is a prodromal stage, and a careful inquiry will reveal that some disturbance of the physical health or some moral shock has been received, producing a profound depressing influence upon a person possessed of a neurotic temperament or heredity. If a man, he may not give up business entirely, but business matters will soon be neglected, and become a source of perplexity. If the case be that of a woman, she will probably become emotional and possibly hysterical. The family physician will be called upon to decide as to what to do. And the question naturally comes up, shall he be sent at once to an asylum, or will it be best to try to keep him at home for a time? The decision should depend upon a willingness to submit absolutely to such rational treatment and advice as the physician may direct, and until sufficient time has elapsed to determine whether improvement is to take place, and whether other and more serious symptoms are to appear. If the threatening symptoms abate, it would then seem to be advisable that some change of environment, and rest from business be enjoined, and all measures to promote sleep and com-

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plete restoration of physical health should be followed, and systematically followed. One great thing of importance is to place him in care of a companion possessed of common sense, firmness, and mildness, and I might say, plenty of muscle, but tact is better than muscle in such cases; also give a course of tonics, and generous living. These will be very useful in the earlier stages of this disease. Now during a period of incubation lasting for two or three months, marked changes may be expected, and if by this time the symptoms do not abate, but the patient enters upon an advanced stage of the disease, during which the symptoms of maniacal disturbances are pronounced, the case is not favorable for treatment at home, and such a case should be sent to an asylum without further delay.

Now, to be a little more definite about the treatment of mania. It must be moral as well as therapeutical. The moral treatment embraces all that concerns the environment, the personal attendants, the room, the discipline—for the insane are amenable to discipline—but this does not imply punishment. All furniture not absolutely required should be removed from the room, as well as all articles that could be used as weapons. Then an attendant should be selected with care and he should give his entire time and thought as nearly as possible to his patient. After a case of mania has become well developed, the friends might as well be resigned to the fact that the disease will run a course of from three to six months, under the most favorable conditions, and during the whole of this time he will require medical aid, watchful nursing, and supervision by day and by night. It must be remembered that your patient is below the normal standard; that he is insomnious; that a constant tissue waste is going on; that the bodily functions are disordered; that the brain is anemic or hyperemic; the quality of blood deficient in its normal constituents, and the nervous system in a state of irritability. The patient needs plenty of food, which may be given freely at meal times and at other times; it is hardly probable that he will eat too much. He needs sleep and fresh air, and if his strength will permit, he should have out door exercise. The attendant should see to it that his patient conforms to his usual habits as to rising, dressing, taking food, bathing, walking, exercise and removal of clothing at night, and if force must be used, see to it that there is help enough that a serious struggle may be avoided. When we come to the medical treatment, we must remember that much of the nervous irritability noticed is due to a defective

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state of the nutrition, and tonics and iron should be administered for a long time; we will often find that the state of the circulation shows that the heart needs support, and stimulants, digitalis and strychnine, are indicated; attention should early be given to the state of the bowels and kidneys; usually there is constipation, and the urine is scanty and ammoniacal. Before these matters are attended to nutrition will not fairly begin. Just here a dose or doses of calomel will do much good. One of the most embarrassing symptoms to overcome is insomnia. This insomnia is due to nervous irritability; to the strong excitement of the feelings from delusions and hallucinations, and a motor disturbance of the peripheral nerves. Functional activity of the brain will cause an excessive flow of blood to that organ which is not removed by the veins in a state of nervous exhaustion, and stasis and engorgement result. Sleep, here, is of the utmost importance, and must be promoted by medicines, and otherwise. The hot bath will serve an excellent purpose, for the well-known reason that prolonged warmth, applied to the whole body, will dilate the capillary vessels, and in a measure relieve the strain upon the cerebral vessels and improve generally the circulation.

Now, as to medicines, we consider opium the most certain and powerful of narcotics, but its administration is not on the whole. satisfactory in mental cases. The resulting constipation is objectionable; but probably the greatest objection to the use of opium is the resulting capillary congestion that follows the narcotism, and as before stated this is one of the things we will be anxious to overcome. Sulfonal or sodium bromide and tincture of hyoscyamus in combination will often be satisfactory. If the vessels are full and the face flushed and turgid the fluid extract of ergot is a good remedy, and may be given in doses of thirty or forty min. three or four times a day. I have been well pleased with the use of hydrobromate of hyoscin one one-hundredth hypodermatically at bed time. It is a most powerful drug, and it is well to begin with a smaller dose and then increase carefully, till we sometimes give one-sixtieth grain. Good authorities say that sulfonal will produce sleep in about eighty per cent. of cases and that usually there are no disagreeable after effects. As a rule insane persons should be given medicine in a liquid form for obvious reasons.

To sum up the treatment of mania, I believe with Chapin, "That in the general management and treatment of mania in the acute stage the indications are to sustain the strength of the patient

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and repair the waste that goes on rapidly, rather than to place the chief reliance upon medication."

There can be no doubting the fact that this can be done more satisfactorily in a hospital for the insane where the regularity of daily life tends to establish orderly habits of living and to develop self-control and the abatement of paroxysms of excitement.

Melancholia: Melancholia is a form of insanity characterized by prolonged and profound mental depression. This form of insanity is often confounded with hypochondria, as in each case the patient is sad and gloomy; but one may be insane and the other not come under this head. The depression of the melancholiac is mainly mental and relates to subjects having a relation to the mind of the patient, while that of the hypochondriac relates mostly to supposed bodily conditions, and may, and often does, progress to melancholia. As in mania and other forms of insanity, here we find derangement of digestion and disturbance of all bodily functions. The blood on which the nutrition of the nervous mass depends is generally impoverished, and the circulation is imperfectly performed from lack of nervous stimulus. But we also find a chain of symptoms here which are the opposite of those of mania. The patient will forsake his accustomed haunts and associates; his life literally becomes a burden to him; he complains of a weary, tired feeling, and, as a matter of fact, is tired and exhausted with very slight mental or physical labor. The gait is slow, the manner is languid, and the patient has a worn, exhausted appearance. He often complains of headache and mental confusion. This condition often exists a long time before either the patient or his friends become alarmed at his condition. Probably the first time the attention of the physician is called to the case, he will find him depressed and dejected in a way that cannot be explained; there is a vague fear of some impending trouble; he imagines all sorts of things will happen to him, and he seems to comprehend his condition, but he is unable to throw off the gloom that depresses him; life seems a burden to him; he reproaches himself for his past misdeeds and failures and indulges in retrospective forebodings generally. His ordinary duties are burdensome. He magnifies all his troubles and has many imaginary ones. He will probably furnish a good history of his troubles, and reason deliberately and well about his condition. His judgment may not be impaired enough to form clearly defined delusions, but if not averted this condition will go on till judgment and reason are abated and this simple

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melancholia will result in melancholia with delusion and agitation, with fixed delusion and a distressing condition of both the mental and physical power; the face will be pale and sallow; the eye will lose its accustomed expression; the appetite is poor, and food is taken very sparingly. Your patient will decide that food is not good for him, and he will refuse it altogether; often he will say it is poisoned or spoiled. The tongue is pale and flabby; bowels constipated, and urine scanty; skin dry and harsh; pulse is slow and soft; pupils somewhat dilated. And there will be insomnia, and in women there will be suspension of the function of menstruation; a decline in weight will almost always be found to have taken place. While your melancholiac will not show homicidal tendencies quite so frequently as in some other forms of insanity, these are cases where we must be on our guard for suicidal tendencies. Many melancholiacs will commit suicide if not carefully guarded. A patient who was under my care last year was the father of quite a family of children, and he had decided that life was not worth living, and that the best thing he could do was to kill himself; while brooding over the matter he came to the conclusion that he could not go and leave his little ones, and so he decided that he would kill them so that they could all go together. This man recovered after six months' treatment at home, although we had planned to send him to the asylum. I did all I could to arouse the secretions, gave him tonics and a most liberal diet of good, wholesome food. This was his first attack. This man was about 45 years of age. I have recently been consulted by two other melancholy patients who have been growing worse for many months, and I have advised the treatment above mentioned. I used sulfonal for the insomnia.

We have to admit that we have no specific medical treatment for insanity, and must remember that the principal object to attain is the promotion of nutrition, and the elimination from the circulation of all toxic agencies. The methods mentioned under the subject of mania, are what I would recommend.

The importance of early treatment in all cases of insanity is well known. The prospects of recovery depend much on what is done the first three months. In cases of melancholia the general practitioner will usually get a chance to treat his patient for a longer period of time than in manias and it will not always be easy for you to decide when the friends ask you to say whether or not the patient should be sent to the asylum. There are often

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good reasons why one such patient should be sent to the asylum while another should be kept at home. Where he is possessed of sufficient means it is often well to try change of occupation and surroundings, but most insane people are not financially able to do this, and this brings us to the fact: That poor people send their insane friends to the asylum early, and recoveries are most common in this class. Melancholia may terminate in recovery in from six months to a year; it may terminate fatally from gradual exhaustion in a few months; it may progress to the chronic stage and last an average period of 15 years. During this period the delusions may be less concentrated and have a wider range; hallucination, usually an unfavorable sign, may appear; self-control become impaired; maniacal outbreaks occur, and mental degeneration proceed until the terminal stage, dementia, is reached.

I had intended to speak of two or three more of the many forms of insanity, but this paper is about long enough, and I have a hobby which I must say something about.

From the best information I can get I believe that at least eighty per cent. of our insanity is hereditary. If this be true, and I fully believe it is, even more than this, I believe it is time that the medical profession should make a combined effort to lessen the evils, the sufferings and the sorrows incident to heredity. If *we* do not do it, it will not be done; it is our duty to do it, and it will be, and ought to be expected of us. It seems to me that it can only be done by legislation, and *we* will have to take the lead. You know what I mean. I mean that a strictly preventive treatment would be the very best treatment. If we could do as the farmer does when he sows his wheat or plants his corn or potatoes, that is, *select his seed*; if we could do as he does in breeding his stock, that is select the best blood, we would within the lifetime of many here, be able to call in our committee who look for locations for new asylums and demand fewer such institutions instead of more.

One day last week I saw an article in one of our daily papers from Dr. Daniel E. Brewer, of Chicago, one of my old teachers. He was speaking of heredity as applied to criminals and it is good enough to repeat for it will apply to heredity on this subject as well.

He said: "The percentage of criminals has increased so rapidly in the United States that we now have one habitual or hereditary criminal in every one thousand persons. Criminals propa-

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gate and multiply unrestrained, and unless we change our laws, will continue to increase, until it is appalling to contemplate the result. If Chicago does not soon have a new code of criminal laws, then it would be wiser to have a Tarpeian Rock, like the Romans did, from which malefactors and degenerates might be thrown to death. We should have laws controlling marriage, so that degeneracy may be checked by preventing the union of criminal, diseased or lunatic couples."

Now can you agree to that? I believe that it is a sin in the sight of God for mental, moral and physical degenerates to propagate the species. We ought to begin by working for a law to regulate the marriage of persons with a known tendency to *mental* degeneration.

DISCUSSION.

Dr. Eastman: The prognosis made by the general practitioner in cases of insanity is sometime really erroneous. I have very frequently seen patients come to the asylum with statements from the people bringing them or speaking for them that they had been getting queer more and more for the last year or two, and that they thought two or three weeks of care and treatment at the asylum would straighten them out. That case I have found as a rule is not going to get well. Another case would be presented with the statement that the person had been taken rather suddenly and had soon become very violent, and it was feared he would never get well. Of course these people do not all get well, but it is in cases like the second one that we look for recovery. A person is taken violently sick with pneumonia, and they die or get well in a few weeks. A person taken sick gradually gets worse and worse and after a year and a half or two years finds that he is not able to keep up any longer, that he is a sick man. Such a man is not going to get well. It is from the acute cases that we get recoveries. Treatment at home turns very largely upon resources in money, resources in house-room, resources to provide or to do nursing, and all these in a great many cases are against doing the work at home. In one case that came under my notice an old gentleman was falling into senility, his mind became unbalanced, he was threatening to kill his family and so on, and I was called in to advise what should be done. It appeared to me first that the party was not likely to live more than a few weeks. The family was located in a fair sized country village, they owned several houses, one of which was vacated and given up to the patient and his nurse. He was left completely

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to servants, a sufficient number being provided, and to his physician, and the old gentleman lived out his life there. Such treatment is utterly impossible to a family in the country, where the doctor lives in town miles away, and they can not do as they would wish, even though it might be well to leave the patient at home. There are some cases that can be well treated at home, where medical treatment and good nurses can be had. But cases from the country are generally better treated at the asylum. About the propagation of degenerates, I considered this as thoroughly as I was able to some two years ago, in a paper which I read before this Society. Some papers at that day came to the rather impotent conclusion that we could not do much. The same procedure ought to be instituted among the human race that is used by the stockraiser with the lower animals. That is, if the human race were in the grasp of a higher race as the animals are under the control of the human race, something might be done. But where are we now to find judge or jury to say who are the degenerates, and who are to be allowed to go on? It is impossible to do it.

Dr. Boyle: I am very glad that the doctor prepared this paper and presented it to us. As a rule general practitioners are in the hope of turning these cases over to the hospitals or asylums. It is rare that we have opportunities or facilities for treating them at home. In some twelve years' practice I have had an average of one case in two years, or thereabouts. It has been apparent to me that it pays a physician to be able to tell when he actually has a case of insanity on his hands. I had one case when I was a partner of Dr. Bryan, which they would not let me see because I was too young. I have in several cases been able to get to the door, and in some cases have come away with a sore head. One old gentleman the people were really able to take care of him at home, and I thought it was a matter of but a month or two any way, and he was taken care of at home. They gave him a room to himself and kept him until he passed away. I remember the paper presented by Doctor Eastman two years ago. I notice that when the subject of limiting the propagation of imbeciles and degenerates is presented we are in the habit of poohpoohing it, and ignoring it, but I believe the time will come when it will be admitted something must be done, and the medical profession should consider this matter. I believe in the agitation of the matter, until a definite public opinion is formed to act in these matters as we do in relation to the dumb animals.

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Dr. Seabrook: I think it is time for the profession to cease talk- and do something. The medical profession now stands toward the public quite as much in the attitude of a body of teachers as in that of mere curers of disease. I think we should take a prominent stand on this question, and have something done.

Dr. Minney: We are getting down rapidly toward the survival of the fittest. Pilcherism, as suggested by Doctor McVey some years ago, seems to be in order.

Dr. Bryan: We do not always know what to do, do not know what the result will be. A man may do to-day what seems best for him to do, but the results affect the human race long after he has passed away. I have some radical views on these questions, and I stand before you to say the time has come for us to act on our ideas. I have given more attention, more thought to these things than almost any man not connected with an asylum. Doctor Pilcher has given his name to something that is to live, it can not be otherwise. I am willing that it should be so, it is right that it should be so. I am here to-day to say everything I can toward extending Pilcherism, until not only our animals shall be bred from pure stock, but human beings shall be bred from pure stock. It is time the State had something to do with this subject. I have lived long enongh to observe the propagation of the insane, and to see the State called upon constantly to build more asylums in which to provide for the care of their progeny. The time has come when the State should do something toward stopping this. One thing I want to say to this Society now, in this line. I would almost ask every member here to pledge himself to bring this subject before their communities, and as Kansas is at the fore in other respects it should be at the fore in Pilcherism. Where I sit at my desk in my office daily I have a beautiful outlook across a very pleasant little open square, but the beauty of that scene frequently becomes one uninterrupted anathema, by reason of the pet dogs of the town congregating there to play upon the grass and among the shubbery, and the ladies of the town who keep pet dogs allow them to run at large at times when their conduct becomes grossly offensive to the sight, in a manner that it is unbecoming to speak of. Why should a lady keep a dog to conduct itself in this manner, any more than a horse or an animal of the bovine species? I say let us extend Pilcherism not only to the horses and the cows but to dogs. There is no reason why ladies should keep pet dogs, and lead them along the streets, and allow them to run at large and

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allow them to destroy the pleasure of others in beautiful surroundings, and while we are considering the application of radical measures to human beings I would advocate the application of the same to dogs.

Dr. Sexton: The doctor spoke abont the advantages the poor insane have, and it is true a poor person becoming insane is quite likely to be sent immediately to a hospital, where he may have all the advantages calculated to promote recovery, while a moderately well to do person able to have a degree of care at home, is allowed to remain at home until the disease becomes confirmed. This is partly because the doctor hesitates to tell the friends that the patient is insane, and partly because the family hesitate to have a member sent to the asylum. Now let us at least give all a good chance to get well in the vicinity, even if they have a little money. A person suffering from insanity suffers from the greatest affliction that can befall him in life, consequently nothing should be spared to restore him to health, and I have seen more mistakes made because of the failure of the family physician to recommend expenditures of money in such cases than in other cases, and people have had reason to blame the doctor for not advising expenditures. In a surgical case where an expenditure of $500 might be recommended and readily acted upon by the family, a doctor will be prompt to give counsel where he would hesitate to recommend an expenditure of $100 to restore a patient to reason. That is illogical and it is wholly wrong.

Dr. Latta: I dislike very much to make a protest against the current of opinion that has been displayed here, as I am satisfied that I am going to be single-handed and alone. But I certainly think that such expressions as have been made here in regard to Pilcherism, and the destruction of the procreating powers of degenerates, ought not to be allowed to pass without protest. The question it must be admitted is an open one, but it can be proven that those who are looked upon as cranks and as mentally peculiar are often those of real genius. Members of families marked with such peculiarities, have been among our most distinguished and brilliant men. If you go around practicing Pilcherism, you may be as likely to wipe out the seeds of genius as anything else. It must be indeed a wise man who could go out into the community today and mark off the line of discrimination, and say on this side all is safe, and on the other side we will have Pilcherism. I remember once hearing a story of Thomas A. Edison, whose genius is now demonstrated to all. Shortly after he be-

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gan his labors of invention he was employed in telegraphing in one of the Southern States, and he was trying to perfect his quadruplex system, by which four messages are transmitted on one wire. There was a man there commenting on Edison, and discussing him with one of his superiors in the telegraph office. "What is the matter with this fellow, Edison," he asked; "Isn't he very peculiar?" "Why," responded the manager of the telegraph office, "he is simply a d——d fool. He wants to send four messages over a wire at once." Now, if that man had had his say, Edison would have been Pilcherized. How many of the brightest men, how many of those who have made a name in the world, would have been destroyed in this way, if Pilcherism had been applied on the judgment of the average of the community? I believe the world will go on for some time yet before Pilcherism becomes the rule.

Dr. R. E. McVey: I believe I read the first paper that was presented to this Society on this subject, and I wrote quite a number of papers sustaining Dr. Pilcher, and I am glad I did so. Of course, Pilcherism would be practiced only on those who were guilty of sexual excesses; that would be the rule. When a man had reduced his nervous force, his sexual force, so as to produce pathological changes in the sexual glands and in the sexual organs with which every physician is familiar, then there need be no mistake. Wherever there is sexual excess there is alteration, that is degeneration. The gland becomes flattened and elongated. The man necessarily has other difficulties besides this. He has difficulty in retention of the vital fluid, and those are the cases that would come under this kind of treatment, especially if this lies behind insanity. Then this measure that has been suggested would be necessary for the protection of the people, to relieve them from excessive taxation; that is the only thing about it. In Illinois I noticed two years ago they had to levy a tax of almost two millions of money for the support of charitable institutions, and in Kansas, as we all know, the legislature has appropriated a vast amount of money for the same purpose. There is a constantly increasing burden laid on thrifty people to support this kind of cases. I remember a case within the last three or four years, when I was called upon to treat a young married man who was practising sexual excesses. I spread the whole matter before him, and he was quite offended. I told him that if he kept on in the way he was doing he would certainly go to the asylum. To my knowledge that man went to the asylum,

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and I believe he is in the asylum now, and the case is incurable. I do not know what portion of the cases in the asylums are the result of sexual excesses, I cannot tell how many, but I think there is quite a large per cent. that go there from such causes. The president suggests that my patient was insane before, but I was not able to detect it. But I am sure he grew worse and worse until it resulted in complete and incurable insanity.

Dr. Uhls (closing): One point that I tried to make was that this treatment of insanity in general practice has not been given due attention. Those who have acted as receiving physicians in our institutions for the insane, and the statements made by juries in the probate court will show, that physicians do not give much time to such cases. They say they can not do so, that other matters demand their attention. But I believe the general practitioner should give some time to this subject, and could do so without infringing upon the attention due to his general work. I hope by this paper to arouse a determination in the general practitioner to give more attention to this matter. It will at least do no harm, and will be of help to the men who have these cases at last. I am gratified that I was able to say anything that would call to your mind other discussions on the same subject. I did not go as far in the paper as you have in the discussion, but I do not believe it is unreasonable or impracticable to act on this subject. We have laws on our statute books prohibiting the marriage of near relatives, but they are not enforced. There are plenty of first cousins living in the married state here in Kansas, regardless of the law. So, there is a law against horse stealing, but horse stealing goes on. I believe that we ought, as physicians, to make a united effort to have laws passed that would regulate the marriage of mental, moral and physical degenerates, but I will say that we ought to begin with the mental degenerates, and I believe we can do it in a way that would be practical. I am not willing to say that nothing in that direction can be done, but to talk about it. I believe that if the physicians who are here now, were every one in earnest about it, we could do something practical in the way of controlling this thing. We might not be able to be very radical at first. I do not think a law could be passed that would warrant Pilcherizing a man because some one called him a fool. But we should be reasonable in this matter, and we, I believe, are coming to it.

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Dr. L. Reynolds, Horton, Kansas, read a paper on "Foreign Bodies in Air Passages."

The lodgment of a foreign body in the larynx, trachea or bronchial tubes, is not a very uncommon accident, and, although fraught with great danger, its degree depends upon the age of the patient, the size and shape of the object, as well as the seat of its lodgment.

In nearly all instances introduction occurs through the larynx, as the result of gravity or suction-force during an inspiratory effort.

Other sources of entrance are by gunshot or stab wounds, or access by ulceration from adjacent organs.

The most common foreign bodies consist of buttons of various forms, grains of corn, wheat, beans and the various articles with which children are apt to play. Under ordinary circumstances nature guards well the threshold of the air passages, but access is frequently gained while her attention is divided.

A relatively large body is apt to lodge in larynx, as this is the most capacious portion of air passages, but smooth, globular objects are apt to be movable under the forces of gravity with inspiratory and expiratory effort. Sufficiently small and smooth objects are apt to enter the bronchial tubes and continue traveling until their progress is arrested by the size of the tubes which they may completely obstruct.

The readiness with which a very small object may interrupt speech, or disturb the voice, is remarkable when its location is in the larynx.

Reflex spasm is apt to occur promptly upon the entrance of a foreign body, and is frequently successful in expelling it. Sometimes inversion of the body and a sharp slapping succeeds in dislodging and throwing off the intruder. This practice, however, may excite a fatal spasm of larynx.

The immediate symptoms are cough, spasm of larynx, causing discoloration of face from disturbance of respiration, and frequently severe pain. This pain and other local disturbance will vary according to the size and shape of the object and susceptibility of the patient.

Symptoms may be almost or wholly negative. The appearance of the sufferer in most instances is like that of one laboring under a severe attack of asthma. The horizontal position may lessen the dyspnea, but upon assumption of erect position, the irritation immediately increases.

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Nature becomes somewhat accustomed to the foreign body in time unless septic symptoms or other secondary developments occur; such as pneumonia, trachitis, bronchitis, abscess or gangrene.

Inorganic substances may become fixed in one position by inflammatory exudate, and the less the motion the less the pain.

Organic substances are apt to undergo changes and may in time become sufficiently softened and decomposed as to be discharged with expectorated matter.

Small, smooth objects are apt to excite little irritation except when in motion.

The determination of the presence of a foreign body, may be very difficult when no history can be obtained. If the laryngoscope reveals nothing, and the history is not forthcoming, hysteria or syphilitic laryngitis may mislead.

With a history of the intrusion of a foreign body into the air passages, diagnosis presents no difficulties.

The occurrence of local pain is of considerable value as an evidence of the location of the intruder.

Such accidents may occur without any history being obtainable, and in such cases I regard exploratory incision as justifiable and wise.

Have had two cases in which the operation was exploratory—one, that of a baby a few months old, who had been seen playing with watermelon seeds. The trachea was opened low down and a careful search made without finding any foreign body, although a great deal of dyspnea coming and going suddenly, and the various other symptoms that ordinarily accompany foreign body existed. Considerable debris was discharged from tracheal wound, and considerable temporary relief followed. Emitics were occasionally administered to relieve the obstructed respiration which occurred in this case. Recovery eventually followed. It is my belief that a melon seed had entered the air passages and that disintegration followed by extension in small bits cured the child.

The second case of respiratory tracheotomy was that of a young lady who suddenly began coughing with great violence, was soon apparently unconscious, and could not be made to speak or utter a sound other than the constant and violent cough. Medical treatment accomplished nothing. Her symptoms grew slightly less violent during two or three days. Her friends gave the history that she was eating cloves, and had two or three in the mouth at the time the seizure began.

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This bit of information with the symptoms led me to make a tracheotomy. A great amount of debris resembling the contents of an abscess was immediately discharged from the wound. Nothing resembling a clove or any other foreign body, was discovered, but entire relief immediately followed.

The case had no hysterical history but manifested such tendency very strongly for some weeks after operation.

It is my belief that her history and symptoms were misleading. That her illness was what is commonly called hysterical, and the initial attack of a series.

The treatment in my opinion should invariably be immediate removal. It will be rare that efforts at removal through the natural channel will be successful, therefore tracheotomy will be mainly relied on.

Whether the operation is above, through or below the thyroid gland depends on the size of the object and the shape of the neck to be operated upon.

Whenever the foreign body is known to have passed low down, or rather when it is not known to be lodged high, the low operation should be chosen as more space is obtained for work and the hemorrhage is less.

The instruments commonly needed are a scalpel, tenaculum, scissors, suitably shaped forceps, retractors and probes. Nothing else seems to me so well adapted to maintain patency of the tube as the common wire nasal speculum. It is self retaining, does away with one assistant, and does not injure the structures involved. A long flexible probe is most convenient for searching the larger bronchial tubes. Enough assistants should be handy to invert the patient to obtain the advantage of gravity while searching after the object. Chloroform is preferred as an anesthetic, which will necessarily have to be interrupted frequently if any prolonged search is required.

Auscultation may furnish a very important aid in locating the body, as the following case operated upon about three years ago illustrates:

A little girl eight years old, while playing with a common shoe button in her mouth suddenly drew it into her trachea. This occurred a day or two before she was presented. When lying quietly in the horizontal position she showed very little evidence of the presence of a foreign body in her air passages, but the upright position immediately brought on paroxysms of dyspnea.

Auscultation showed the respiratory murmer normal in the left

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lung; also in the posterior portion of right lung, but the sounds were totally suppressed in the anterior portion of the right lung, indicating entire occlusion of the anterior tubal division beyond the second bifurcation.

This left no hope of reaching and grasping the button by any kind of a forceps, as it was completely wedged in the tube with two curves existing between its position and the external wound. Considerable time was consumed in searching for and reaching the body by means of a long, slim, flexible probe, while the patient was held in the inverted position, the patulency of the tracheal wound being maintained by a self-retaining wire nasal speculum. Contact of the probe with the button was readily recognized, and a certain amount of rotary motion of the probe after its point had been passed beyond the obstructing body caused the button to drop into the wound, where it was quickly removed. Considerable purulent discharge accompanied the button.

The tracheal wound was made ample and low down. Uncomplicated recovery followed.

It is well in the primary search for a foreign body, to explore the chink of the glottis with the finger, as lodgment may be maintained by suitably shaped objects at that point.

In the after treatment the air of the room should be kept warm and moist by the constant discharge of steam in the room. This precaution is especially necessary, where breathing is to be maintained for any length of time through the wound, as air which has not passed through the natural channels, into the lungs, is apt to be very irritating and may cause pneumonia, or the inflammatory complications. As perfect asepsis can hardly be maintained the wound should not be entirely closed by suture. Nature soon closes the unnatural opening.

Wherever it can be avoided an anesthetic should not be given when the stomach is full of food. By a neglect of this precaution I came near losing a case by suffocation by stomach contents entering larynx on its way from the organ in vomiting.

DISCUSSION.

Dr. McClintock: These cases of foreign bodies in the air passages are of considerable moment to the man who is called upon to see them. They are cases that come up in emergencies, and most cases are those of children, so that it is almost impossible to make a diagnosis, or to make any kind of an examination that will show what the trouble is, even when it seems clear from the history that a foreign body is in the air passage. I have seen a

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difficulty in breathing when the obstruction was in the esophagus. I saw a case with Doctor Grubbs in this city, a few years ago. I was operating in a private house, when I was suddenly called by persons laboring under great excitement, who stated that a child had something in its trachea. I took a knife and two or three pair of forceps and ran across the street, and when I saw the subject I said "Why, doctor, this child is dead." Dr. Grubbs said, "Oh, no, it was struggling for breath a moment or so ago." I opened the trachea to see if the child was alive, passed the finger into the trachea, and in the trachea between the vocal cords, I took out from the throat a three-quarter inch screw, together with three grains of corn. The corn was above the screw, the screw having dropped down between the vocal cords, so that the child was dead apparently for want of air. We set up artificial respiration, and kept it up for three-fourths of an hour when we were rewarded with a live child, and the child is living today.

Dr. Chas. Gardiner: You have heard of a truly brilliant result in one case, now I will speak of one or two not so fortunate. I was called to see a child that was supposed to have some body in the air passage, but I was not able to discover anything. The child lived but a short time, and being given an opportunity to make a post mortem, I found a cherry stone in the bronchial tubes. I saw another case of a child who was supposed to have inhaled a kernel of corn. This happened in Emporia. Doctor Longenecker and some others saw the child, and three days after we operated by tracheotomy, but were not able to find the foreign body. The child died, but we were not allowed to make a post mortem. I have seen Doctor Gross, of Philadelphia, operate and fail to find the foreign body. The reader of the paper was very fortunate in the breaking down of that melon seed. Now as a rule if a melon seed gets into the trachea, and remains several days, it begins to sprout. I think it would be well if more of our members would report some of their unfortunate results.

Dr. Leslie: I was going by a house a few days ago, having no instruments with me, when the lady of the house called on me to come in and see a little child about a year and a half old, who, I found struggling for breath and apparently choking. I asked what the child had had which might have gotten into its throat. She said the child had been playing with a piece of steel about three inches long, or thereabouts, and three-eighths of an inch in diameter. Taking this hint I told the mother to hold the

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child up with its head downward, and with a very little effort the steel rod was dislodged and dropped out, leaving the child all right.

Dr. Logan: With reference to determining the location of a foreign body that has happened to pass into the air passages, it is very easy to mistake the location of a foreign body in these cases, from location in the trachea to location in the esophagus. There are two points of constriction where a body is likely to lodge and give about the same amount of dyspnea. If it lodges in the first constriction of the larynx, you will find that there is a slight wheezy sound. Any ordinary body that is liable to lodge in the tubes of the œsophagus or trachea, if by any means it passes the first constriction, it will certainly stop at the second constriction. But, until the location of a foreign body is actually found, it is difficult to diagnose the position with reference to the œsophagus or the trachea. A penny, for instance, swallowed by a child, may give about the same dyspnea in the one case as in the other.

Dr. Minney: There are two points of diagnosis which I recall, one of which may not be familiar, and that is the *x*-ray where there may be time, and the foreign body is metallic. In one case where I was called there was doubt whether the body was in the œsophagus or in the air passages, and the manner in which I determined that it was not in the air passage was that the child was able to drink a considerable quantity of water, but the water did not pass into the stomach, but was vomited up. I diagnosed my case in that way, treated accordingly, and the child lived.

Dr. C. F. Leslie, Clyde, Kansas, read a paper on "Injuries to the Head, Including Fractures of the Skull, with Report of Several Cases."

Mr. President, Ladies and Gentlemen: My object in this paper is not to present anything new, but to emphasize the importance of proper treatment in all injuries to the head.

All injuries to the head should receive careful attention, and cases of this character should not be dismissed until the danger period has passed. Apparently slight wounds have often been followed by the most serious results. Likewise, the most severe injuries should never be abandoned as long as life remains. While on the one hand persons have died from apparently trivial contusions or scalp wounds, on the other hand recoveries have

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followed the most serious injuries, not only to scalp and skull, but to the membranes and brain substance.

First dressings and advice are of the utmost importance in injuries of this character. Many grave symptoms and complications may be forestalled by proper treatment at first. The surgeon should not only give the proper directions, but see that all his orders are obeyed to the letter. By such a course precious lives will be saved, and much needless suffering and regret avoided.

Injuries to the head may be classed as wounds of the soft parts, and fractures of the skull, or both combined.

Fractures of the skull are divided into fractures of the vertex, and fractures of the base. Fractures of the vertex may be either direct, resulting from violence, as blows or falls received at the point of fracture, or indirect, as a fracture radiating or occurring some distance from the point of contact of the force producing it.

All conceivable degrees of fracture may be met with, from the merest line or fissure to the crushing in of the whole bony structure over large areas of the cranium.

Diagnosis of vertex fractures is usually a simple matter, but when any doubt exists thorough examination should be made in order that the proper treatment may be adopted. Incision or enlargement of the scalp wound is the proper course where a perfect diagnosis cannot be made without. Of course antiseptic precautions must be used in all cases.

There are two principal causes of fracture of the base of the skull: One, such as gun-shot wounds, bayonet or sword thrusts, or punctures from any sharp or pointed instrument, causing direct fractures. The other, fractures caused by blows or falls striking against the opposite side of the skull. These are classed as indirect fractures of the base. There are other ways in which a fracture at the base may occur, such as an upward thrust of the spinal column against the condyles of the occipital bone, or by lightning; the lower jaw has also been driven with such force against the base of the skull as to fracture it.

Direct fractures of the base of the skull are very rare in civil practice, a very large majority of such cases being confined to army practice, and a very frequent cause of these fractures is the impact from projectiles.

The surgical history of the War of the Rebellion contains a great many cases of this kind, and, strange to say, there were many recoveries. Packard collected from this history one-hundred and thirty-five cases where recovery was more or less complete.

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Indirect fractures of the base are by far more frequent than direct, so much more, indeed, that it is claimed by good authorities that they form the greater part of the head fatal injuries in civil practice. The location of indirect fractures of the base of the skull are divided as to frequency in the proportion of about one-fifth each to the anterior and posterior fossæ, and three-fifths to the middle fossa, though in severe cases the fracture may involve two, or even all three of the fossæ at the same time.

Symptoms.—The only symptoms that can be depended upon as indicative of fracture of the base are either the escape of some of the cranial contents, or an injury done to the nerves as they emerge from the skull. The contents which may escape are blood, serum or brain substance, blood being the most common.

In order that the escape of blood may take place, the line of fracture must involve some of the large vascular channels lying at the base, and must open a road through which the blood may get out of the skull, where it may become visible. A fracture of the base may manifest itself by an escape of blood in the cellular tissues of the orbit and eyelids; by bleeding at the nose, or subsequent vomiting of blood; by bleeding from the ears; by an escape of blood into the mastoid region, or into the tissues at the back of the head. The blood that reaches the back of the orbit soon makes its way forward, readily infiltrates the loose cellular tissues of this region, shows itself under the ocular conjunctiva, and subsequently spreads into the eyelids. Effusion of blood under the ocular conjunctiva is, then, a sign by which a fracture of the base may be recognized, yet a fracture of the base may exist without an effusion. Bleeding from the nose or mouth or vomiting blood occurs not infrequently after head injuries, but the great vascularity of these parts renders this bleeding of much less value as a diagnostic sign than bleeding from the ear. Bleeding from the ears, after severe injuries of the head, has for many years been held as one of the most valuable diagnostic signs of fractured base, but to be of any value it must be of considerable quantity, and must continue for some time. Holmes says that with such a bleeding we may safely diagnose fractured base, running through the petrous portion, and opening up a communication between the cavity of the tympanum and some of the numerous channels which surround this bone. Packard says, "Out of thirty-two carefully dissected cases of fracture of the middle fossa, involving the petrous bone, in fifteen cases the flow of blood was profuse and continuous." Park says that "exophthalmus"

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caused by blood accumulating within the orbit, "is most significant but not common."

In cases where the fracture of the petrous portion communicates with the venous sinuses on the inside of the skull, and in which there is no rupture of the membrana tympani, there can be no bleeding from the ear, but in such cases the blood finds its way through the Eustachian tube, so there may be bleeding through the nose or mouth, or subsequent vomiting of blood. When the hemorrhage is profuse, even if the tympanum be ruptured, the blood may pass through the Eustachian tube so that there may be bleeding from the nose, mouth and ears at the same time.

Prognosis.—Park says that "non-penetrating injuries, when promptly and properly attended to, have for the most part a favorable prognosis, but every penetrating wound of the cranium is a condition justifying a grave prognosis on account of the great danger incurred of infection. Hence, every wound whose history and appearance indicate that penetration may have occurred should be subjected to the most rigid scrutiny and care."

Prognosis in fractures of base is always grave. It used to be considered in such a case, that if the patient died, he probably had sustained a fracture of the base of the skull, but if he lived, the fracture did not exist. Gross says: "Fracture of the base of the skull is one of the most serious of accidents; if it do not always terminate fatally, the number of recoveries are so few as to form merely an exception to the law, which is regarded by many, and very justly so, as general." Park says: "The majority of basal fractures are fatal." Nancrede says: "Death is the usual result of these fractures."

Treatment.—Wounds in the soft parts must always be antiseptically dressed to be free from danger.

Where cuts, lacerations, or contusions occur in the scalp, it should first be shaved and thoroughly cleansed, not only for the benefit of the external wound, but to avoid infection of the interior of the cranium through the venous foramina in the skull. Whenever there is penetration into the cranial contents or any laceration of the membranes or brain substances, then the wound must be thoroughly and antiseptically cleansed at once, and all lacerated tissues and fragments of bone or other foreign matter removed. Any other course would be to invite disaster, and should be condemned.

Simple fractures of the vertex of the skull possess little surgi-

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cal interest, unless they are accompanied with some evidence of disturbance of the brain or its membranes.

If there is no depression of bone, no evidence of compression or hemorrhage or laceration of the inter-cranial tissues, then the wound should be closed over, after being cleansed, and treated as an external injury.

While the treatment of these simple fractures is for the most part expectant, yet the proper measures should be adopted to avoid inflammation. Complete rest should be enforced, the bowels kept well open, the kidneys active, and ice or hot water applications to the head.

Depression of any portion of the bone in skull fractures calls for surgical interference, and if there be hemorrhage or brain compression the surgeon should operate at once.

Park says: "Where there are no brain symptoms and no skull symptoms in fractures of the vertex, leave the case alone; when either of these is present, it will always be wise to operate."

Trephining is justified, yea, demanded, when depression of bone exists that cannot be otherwise elevated, whenever there are symptoms of inter-cranial hemorrhage or compression of the brain, or when there is unmistakable evidence of pus in the cranium; and if a clear diagnosis cannot be made, it is undoubtedly better to trephine when pus is absent than to neglect to do it when pus is present. Trephining under antiseptic precautions is not a dangerous procedure, while pus in the cranial cavity, if not evacuated and the cavity cleansed, very probably means death. Of course in this, as in everything pertaining to medicine and surgery, the *Vis Medicatrix naturæ* should not be lost sight of, but everything done should be on the plan of assisting nature.

Case 1.—Mr. S., aged 52, fell from a saw mill to the bed of a rocky stream, striking his head upon some sharp stones; distance of the fall, sixteen feet. The whole scalp was literally peeled off the skull, the scalp wounds that required stitching measuring twenty-three inches in length. The man never lost consciousness. I saw him one hour after the accident. This was in my early practice, before the days of antiseptic surgery. Having shaved the scalp and cleansed it with hot water as well as I could, I took over eighty stitches with a small needle and fine silk thread, and applied ice water to the whole surface, and continued it for several days. The wounds healed rapidly with very little pus. There was no fracture of the skull in this case, and patient made an uninterrupted recovery without any symptoms of brain or meningeal trouble.

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Case 2.—Mr. A., aged 66, in a quarrel with a neighbor, was struck over the right parietal bone with a stick of wood about sixteen inches long and two inches in diameter. The parietal bone was fractured and depressed about one-half inch. This occurred about 9 o'clock in the evening. I was summoned next morning at 8 o'clock. On reaching his home I found the patient dead. History of the case, as given by the family, was that after receiving the blow he did not appear to be much injured and went to bed in a short time, when he soon went to sleep. In the morning he could not be aroused and they at once sent for me. Examination revealed, besides the fracture, a rupture of the middle meningeal artery with a large clot pressing upon the brain. By prompt surgical aid this man's life could probably have been saved. A strange coincidence in this case was, that the neighbor who struck this man, after being sent to the penitentiary for manslaughter, was hit on the head in the same place as his victim by a billet of wood thrown from a circular saw, and killed.

Case 3.—Mr. W., aged 50, was kicked by a horse on the left temple. The skull was crushed in, the ragged edges of the bone penetrating through the membranes into the brain substance, and quite a portion of brain substance escaped. I was telephoned for when the accident occurred, but being out of town, a homeopathic doctor was summoned, and he took as counsel an old physician retired from practice. They made no attempt to replace the fractured bone, or even to cleanse the wound. The next day I called to see the patient, and found both doctors there, waiting and doing nothing. The patient was conscious and had no fever. I urged upon the doctors and the family the great necessity of replacing the bones, removing fragments and mangled tissues, and cleansing the wound, and offered to do it myself, but the doctors said his brain was running out and he must not be touched. Their counsel prevailed, and the patient died one week later. I have always felt that this man might have stood a fair chance of recovery if he had been properly treated.

Case 4.—Mr. S., aged 45, was stretching wire for fence when the wire broke, and the end of the stretcher struck him on the right side of the head, over the parietal bone, making a scalp wound one-half inch long. There was no visible fracture or depression of bone. This occurred about 3 o'clock in the afternoon. Mr. S. did not consider that it amounted to anything,

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and kept on with his work until evening. He ate his usual supper and went to bed. In the morning he could not be aroused, and I was summoned. He lived seven miles from town, and when I arrived he was dying, living not more than five minutes after I entered the house. An autopsy was denied, but the symptoms and result plainly pointed to the rupture of a small blood vessel, and death resulted from compression of the brain. Early trephining would probably have saved this case; at any rate, I would have resorted to it, had I been called in season.

Case 5.—Mr. L., aged about 30, while crossing the Rock Island Railroad track, was struck by a fast train going at the rate of seventy miles an hour (as the train men testified). He was thrown about thirty feet, striking his head against an embankment of earth. His left thigh was fractured, but there were no scalp wounds or fractures of the skull, though his head made a deep impression in the embankment. This patient was first attended by two other physicians, who had the case about twelve days. Mr. L. soon became very nervous, excitable and abusive to the doctors and attendants. He being naturally of an irritable disposition, the doctors, thinking it was owing to natural meanness, took offense and refused to attend him. I was called and diagnosed his case as meningitis. His temperature was 103, pulse very irregular, and he had that anxious expression of countenance that is so general in such cases. He soon became violently delirious. It was impossible to nourish him except by enema. In a few days he went into a state of coma from which he never rallied. It is doubtful if any treatment would have saved this case, though the fractured femur united.

Case 6.—Mr. W., aged about 35, was struck with a hammer while in an altercation with a man over some business matter. He received the blow at the junction of the left parietal with the frontal bone. There was a semi-circular scalp wound three inches long, but no fracture of the skull. Mr. W. was rendered unconscious for about an hour from the blow. I dressed his wound and put him to bed. The next day he was able to sit up, but unable to walk without aid. There were some symptoms of compression for two weeks: viz., nausea, vertigo, double vision, and partial paralysis of the lower extremities. It was more than a month before these symptoms entirely subsided. I mention this case to show that very probably meningitis may have been forestalled by careful treatment and complete rest, which was enforced as long as the symptoms demanded it. During the first

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day or two, I kept in constant readiness to trephine, but the symptoms did not really demand it, and I followed the expectant plan which proved successful.

Case 7.—George Stine, a brakeman on the Missouri Pacific, was struck by lightning near Clyde, Kan., on August 2, 1897, and knocked from the brake on the top of a freight car, where he was sitting at the time, while the train was running at full speed. He was severely burned by lightning on the right side of his chest, on the right hip and buttock, and in the right groin. A handkerchief which he wore about his neck was cut squarely in two and a portion of his watch and chain was melted by the lightning. He fell head foremost from the top of the brake, striking the ground on the side of an embankment, where the road-bed had been raised several feet, making his fall about fourteen feet, with the momentum of the train added to the fall. When taken up he was insensible, and had two scalp wounds, one about one inch long over frontal bone on right, and one four inches long over left parietal bone. He also sustained, as the symptoms afterwards showed, two distinct fractures of the base of the skull. At the time I saw him, about one-half hour after the accident, he was entirely unconscious, either from the effect of the lightning, or from concussion, or probably both. His breathing was stertorous, pupils dilated, temperature 97, pulse 48, irregular and feeble; blood was running from nose, mouth and ears. He also vomited blood, more or less, for thirty hours. Would not have been surprised at his death at any moment while we were moving him from the train to the hotel, or while his wounds were being dressed the first time. The scrotum was nearly torn off, and there was a deep laceration five inches long in the right groin. The tissues here were burned black, would not hold stitches, sloughed in a short time, and subsequently healed by granulation. The scalp wounds and the burns on the body healed in a reasonable time. On the third day the symptoms of concussion had nearly subsided. He then began to take nourishment and recognize friends, but he was entirely deaf. On the second day, clots of blood began to form behind both eyeballs, causing them to bulge forward. The blood also infiltrated the tissues beneath the conjunctiva, covering more than half the eyes with dense clots of blood. There was marked ecchymosis about the lids and orbits, and beneath skin in left mastoid region. These clots and ecchymoses began to be absorbed on the eighth day. The hemorrhage and serous discharge from the ears,

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which had been quite profuse all the time, ceased on the tenth day, and on this day we took him to the hospital at Kansas City. He stood the journey well and made a good recovery, going back to work January 1. My diagnosis was that, in addition to his external injuries, the effects of lightning and concussion of the brain, he had sustained two indirect fractures of the base of the skull, caused by the head striking the ground. Dr. Armstrong, of Greenleaf, Kansas, and Doctor Priest, of Concordia, Kansas, saw the case with me and agreed with this diagnosis, which was also confirmed by Drs. King and Hamiel, of the Missouri Pacific hospital of Kansas City, Missouri, and Drs. Thompson and Punton, of Kansas City.

The treatment consisted at first, after his wounds were dressed, of ice cold applications to the head, and dry heat to the body and extremities. As soon as the patient could swallow, five grains of calomel were given, and the dose repeated in four hours. Morphia one-fourth gr., atropia one-one-hundred-fiftheth, strychnia one-sixty, and ergotine one-tenth were given by hypodermic injections about every six hours for ten days. The bowels were kept open and cold applications were continued to the head. The ears were frequently cleansed and plugged with absorbent cotton. The bromides were given in moderate doses by mouth after the patient was able to swallow. There was also quite a free hemorrhage from the wound in the groin, which might have had some influence in relieving brain symptoms. The two important features in this case are the lightning stroke and the fractures of the base.

Case 8.—Mr. V., aged 18, one of a family of thirteen robust children, on December 10, 1898, while setting on top of a high load of trunks, and driving a team at full speed around an icy corner, was violently thrown from the load, striking his head upon the ice. He was rendered unconscious for a few minutes, but soon recovered consciousness and regained his feet without help. There was quite a contusion of the scalp on the crown of his head, but he made light of the accident and did not consult a physician. He complained, however, of numbness and tingling in his feet and legs, and the family say, to use their expression, "There was quite a discolored spot at the back of the head and neck which came on two or three days after the accident, and lasted a week or more."

He kept about his ordinary work until New Years' morning, when, in company with several boys he stood on his head three or

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four times. Soon after this he complained of severe pain in the head, and before evening was violently delirious. A messenger came for me, but being unable to go, another physician was summoned. He diagnosed his case as lagrippe and treated him for that disease four days. At this time the family insisted on my taking the case. At the time I first saw him it took four strong men to keep him in bed. I diagnosed his case meningitis, and gave him large doses of morphine, bromide and chloral, under the influence of which he soon became quiet, but not conscious. This was in the night. The next day I learned the history of the case, which explained the symptoms. I gave him calomel freely, shaved the head and applied ice bags to the head and neck, and a large fly blister to the epigastrium. His bowels were moved freely, kidneys stimulated, and the opiates and bromides continued. Dr. S. C. Pigman, of Concordia, saw the patient with me on the second day after I took the case, and agreed in diagnosis and treatment. This line of treatment was continued, except we were obliged to change from ice to hot water applications to the head, on account of the depressing effect of the ice. We maintained a long and hard fight for life in this case, but lost in the end. He never regained consciousness fully during his entire sickness, but had partially lucid intervals in which he was able to recognize friends. He took nourishment freely and ravenously, in the shape of milk, beef tea, beef peptonoids, eggnog, scraped beef and raw egg, and milk, all the time, also water in large quantities, yet the abdomen had that deep sunken appearance all the time, so characteristic of meningitis. His condition can be partially described by saying that for fifty-five days his bowels and kidneys acted without consciousness on his part. We succeeded by careful nursing and frequent bathing in warding off bed sores, and keeping up a fair degree of strength. How much longer he would have lived, or whether he would have ultimately recovered, I can not say, but he died on the fifty-fifth day from acute congestion of the lungs, following one of our severe blizzards. We failed to get an autopsy in this case. It is possible there was fracture of the base of the skull. The statement of the family that there was ecchymosis in the mastoid region occuring a few days after the accident, would indicate fracture in the posterior fossa, but this is not certain, and probably had this patient consulted a physician immediately after the accident, and been properly treated, his life could have been saved.

In contrast to this case, allow me to mention one which occurred

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about the same time. A lad fifteen years of age, in company with other boys, was running his horse, going home from town in the night. The horse stumbled throwing the boy over his head into the ditch by the roadside. His head struck against a lump of ice, fracturing the outer table of the frontal bone. The fracture was two inches long and three-fourths of an inch wide. The bone was depressed three-eighths of an inch. He was unconscious several hours. I saw him two hours after the accident. After properly dressing the wound, I prescribed perfect rest, keeping the bowels open, and giving the bromides as sedatives, with ice or hot water applications to the head, as was most comfortable. Gradual recovery followed without any bad symptoms.

DISCUSSION.

Dr. Jackson: The paper which Doctor Leslie has presented is one of unusual merit, being upon a topic which I consider of as much importance to the profession in general as any subject which could be presented before them. It is of interest not alone to the surgeon but to the general practitioner, for upon him rests the first responsibility as to what shall be done in these cases. A few years ago the bulletin boards of the hospitals were constantly filled with reports of operations affecting the cranial cavities, working upon the theory that a local injury was the inducing cause of epilepsy, and a great amount of work was taken up in this line. The results, however, have not been at all satisfactory. It has been sufficiently demonstrated, however, that too much attention can not be given to these cases, even when apparently trivial in character, and followed by rapid convalescence. Many of these cases have given rise to hopeless brain degeneration, the effort to cope with which has been wholly unsuccessful.

Dr. F. B. Tiffany, Kansas City, Mo., read a paper on "Dry Electric Uniform Heat as a Therapeutical Agent in Ophthalmology."

Dry electric continuous uniform heat as a therapeutical agent in ocular surgery has proven in my hand for the last year a reliable agent in many of the diseases of the eye. I have used it in both acute and chronic affections with most satisfactory results. We, as surgeons and physicians, well know the good effect obtained by uniform dry heat. We are also aware of the bad effect of unsteady varying heat, especially moist heat, which changes constantly, perhaps from a warm temperature to a low, tepid or

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even cold one, giving the action of a catoplasm, promoting suppuration. Dry uniform continuous heat of a high temperature never promotes suppuration, but on the other hand has a tendency to abort it, to reduce the temperature, mitigate pain, and give relief and repose to the sufferer. Until electricity came into use we had not found the means of controling and maintaining a uniform quantity and quality of uninterrupted heat. Every doctor will caution his patients when using hot applications to keep them of a uniform temperature, if possible, avoiding any change from hot to tepid or cold, knowing as he does, the bad effect of such treatment. Heat applied by means of electricity, controlled by Rheostat can be held indefinitely at any desired temperature; it thus acts as an antiphlogistic, an anodyne, without any of the depressing effects or reaction liable to follow drugs or stimulants. I have used this heat more in ulcerations of the cornea than in any other affection of the eye, always with the effect of checking the progress of suppuration and aborting the disease where necrosis seemed imminent. For any form of iritis it stops the pain, dissipates the blood from the ciliary region and iris checking the disease, where the eye I believe would have been lost without this agent. I have in mind one case in particular in which I made a preliminary iridectomy of an eye which was cataractous and had been for a long time affected by trachoma, pannas and chronic iritis; I had cured the trachoma and pannas. I made an iridectomy which promised excellent results, but two or three days subsequently the unruly patient exposed his eye to bright light, bringing on a most severe acute iritis with a copious exudate of plastic serum. The man groaned and shrieked with pain and when I got to him he was totally blind of this eye which was as hard as a stone with other symptoms of acute glaucoma. I feared that the eye was irremediably lost. I applied the electric dry heat at intervals day and night maintaining uniform temperature; almost immediately after the heat was applied the pain subsided and soon the intra-ocular tension lessened until the normal was regained. The exudates were eventually absorbed, even without synechiæ, and vision was regained. For several weeks he had twinges of pain but as soon as the heat was applied the eye would instantly become quiet. In several cases after cataract extractions, where there was pain and soreness with symptoms of iritis following, I have used the electric dry heat with the effect in every case of dissipating the pain and ridding the eye of all redness and soreness.

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From my personal experience I would recommend this agent in cases of all forms of ulcerations of the cornea, in all forms of keratitis, iritis, glaucoma, and after extraction of cataracts. So confident am I of the excellent results of this dry electric uniform heat in ophthalmology that I have placed Rheostats in a large number of the rooms and the ward of the University Hospital, and most of these are in constant use. Since introducing this agent I have employed it in forty or fifty cases, such as different forms of ulceration of the cornea, phlyctenular keratitis, hypopion, onyx, iritis of the various forms, acute glaucoma, and as a subsequent treatment after extraction of cataracts, or needling of lens, and without any exceptions with most satisfactory results, and I can heartily recommend it to you as a most valuable agent in ophthalmology.

DISCUSSION.

Dr. Goddard: I want to say a word in commendation of this paper. I have myself made use of the method presented by Dr. Tiffany, and with good success. I think it acts as a stimulant, and acts very well indeed. The device that Dr. Tiffany refers to has a great advantage in the absolute uniformity of its action, as it can be regulated to any temperature and maintained at any degree for any time desired. It is much more advantageous than hot water, the only drawback being that it is not at all times available.

Dr. Minney: I am much pleased to have heard this paper. I have seen a case in which this device was used, and have read Dr. Tiffany's report on it, and I think it has a place in our practice, but a very limited place. We cannot use it in the country, unless we get wires all over. It would be practicable of course, in hospitals. I want to ask Dr. Tiffany what success he has had with this means as compared with his success before. Do results show a decided advantage in the use of this method over those formerly used? Now, secondly, I think a high degree of heat, long-continued, has a relaxing effect. The doctor does not state the degree of heat used, but speaks only of a high degree; still I take it for granted that it is a degree of heat producing stimulation, and a degree of heat that would produce stimulation would in time effect relaxation which would be injurious. Now, so far as hot water is concerned, we use it as hot as it can be tolerated by the patient, for a short time, and then cease its use, and this allows them time to regain their strength, and it is not

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debilitating. Electricity is excellent in many cases, but, as I remarked before, its usefulness is limited. I am not satisfied with the doctor's paper in its omission of information as to the success that he had before, and comparison with later results. I think the doctor was quite successful in his practice with former methods. I have had no experience, however, in the use of electricity in these cases, and am not prepared to speak with authority.

Dr. Tiffany: There is not much more for me to say on this subject, except to emphasize the importance of the uniform heat that we get from electricity, that you can not possibly get from any other means, certainly not from hot water. You gauge this by the rheostat, set it as you determine, and continue it for any time desired. You can use it in the residence, can use it in the home, anywhere that electricity is. Where you do not have street current, the storage battery can be availed of. Of course the best place is in the hospital. The point is not in the use of electricity but in the uniformity of the heat. After the extraction of the cataract I have found it very beneficial indeed. The apparatus is very light. I should run it up to about 135 degrees. Of course it can be run up higher than that, regulated to any degree required. In Europe I have seen hot water used with a coil but the heat could not be kept up uniformly. I procured a coil adapted to this purpose and brought it home with me, but never used it.

Dr. R. E. McVey, of Topeka, read a paper on "Tinea Psychosis, with Report of Case."

The patient came to my office about April 22d. He had been taking care of calves which had ringworms about the eyes. He said the eyes of the calves were swollen and maturated. While treating the calves he did not use any antiseptics on his hands, and the result is he communicated the disease to himself. Tinea psychosis is produced by a vegetable parasite. These parasites belong to the family of hyphomycetes, that of moulds and fungi. The action of these vegetable growths is purely local. The lesions are produced by their local action upon the elements of the skin and its appendages. There is no absorption into the blood or the system at large. These eruptions are always acquired from outside and when communicated from one person to another, or developing elsewhere on the same individual, it is by direct, or indirect transferrence of the spores or germs of the par-

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asites to and upon the affected part. The parasites, or spores, had been communicated first from the calves to the patients' fingers, then from his fingers to the hair follicles of the face. Vegetable parasites when transferred from the lower animals are always more virulent than when transferred from one individual to another. The severity of this case is conclusive proof that the disease is transferred from the cattle, or calves, as he says.

Within about two weeks after he began taking care of the calves an eruption broke out upon his face, resembling generally that about the eyes of the calves. The eruption first made its appearance in the neck and about the hair follicles of the beard. At first, the eruption was superficial and in the form of ring-worms, but, later, the deeper structures of the skin were involved, that of the hair follicles and sub-cutaneous tissues. After the deeper invasion of the disease, one lump appeared at first on his neck under the jaw. After a week or so, several more made their appearance, and within a month there were quite a number on the same side of the face. Several on the back of the neck and others made their appearance upon the opposite jaw—both sides of the face becoming involved. The cervical glands were also swollen and tender from the absorption of pus which had made its appearance in the nodular swelling in the face and neck. Usually, the discharges from the tumors are of a sero-purulent character, but in this case the discharge was pure pus. The only affections for which tinea psychosis might be mistaken, are non-parasitic psychosis, pustular eczema, acne, favus and syphilis. In non-parasitic psychosis, however, the inflammation is superficial in character, and characterized by the formation of pustules. In tinea psychosis the deeper layers of the skin as well as the hair follicles are involved, and tubercles and nodules are formed in the affected area. Non-parasitic psychosis is usually accompanied by intense itching and burning, while in tinea psychosis these symptoms are seldom very marked. Non-parasitic psychosis frequently involves the upper lip, while tinea psychosis is rarely, or never, observed there. In this case the burning and itching were absent, and the upper lip was not involved. Finally, the hairs are not affected in the former disease, while in the latter they are twisted and broken off, spontaneously expelled from their follicles. In doubtful cases the diagnosis can always be placed by microscopic examination. Under the microscope in this case we found both the mycellia and the spores. The latter were in great abundance and large, placing the diagnosis beyond a doubt.

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In pustular eczema, other portions of the face are involved as well as the hairy portions. The disease is more superficial and always accompanied by intense itching. The syphillides always give a history of eruption elsewhere besides the face and the history behind it is the diagnostic symptom. The itching is absent, and does not produce the boggy and nodular appearance of tinea psychosis.

There is quite a large variety of trycophytinea spores which are capable of producing diseases in the skin, and may be found both in the lower animals and in the human family. These spores are divided into large and small, yet it is claimed that the large spores are found only in the lower animals. The large spores, or meglasporon, which occur in the horse or cow, give rise to pustular lesions as seen in this case. Some of the smaller spores, which are found usually in the skin of man, are superficially imbedded.

They are found usually just beneath the corneous layer, and are easily destroyed by the various preparations of sulphur, while the larger spores, or meglasporons, are imbedded in the deeper structures, and do not always yield to the sulphur treatment. In fact, I think some of them are little affected by sulphur.

Spores which have the property of developing into independent organisms, or individual spores presenting innumerable transitions from differentiated cells or combinations, may be lodged in the skins of individuals who have a skin which has not the power of disinfecting itself, thereby causing various forms of irritations. The skin is the best place to study the spores of this form of disease, because it is spread out over large surface where its diseases can be brought into view, and all forms of cryptogenic life may be put under the microscope where it can be studied, while other organs of the body being concealed from our observation escape such thorough investigation. In the last few years various forms of the tinea trycophitinea have come under my observation, while holding clinics at the Kansas Medical College. Negro children are especially subject to a superficial form of the tinea trycophytinea. Tinea tonsurans is sometimes produced by the megalaspores, or large spores. Two years ago a young man came to me for treatment, who had three large patches on his head, which consisted of large spores. The disease had been very stubborn and had been

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treated by many physicians before he had come to me, and by specialists in other cities.

As the patches were large and boggy and nodulated, I diagnosed it to be tinea tonsurans caused by the large spores, of a pus making character, and commenced the treatment by sulphur precipitate and vaseline, without any result. I then tried bichloride of mercury four grains to the ounce, equal parts of alcohol and water, without any improvement, but when I raised the mercury to ten grains to the ounce of alcohol, causing its absorption into the subcutaneous tissue, within a week's time there was marked improvement, and within three weeks time the eruption had entirely disappeared. I now have a young lady of sixteen years who has the superficial or small spores which infest the hairy parts of the axilla and the mons veneris. Those parts are covered with ring worms and thickening of the corneous layer, and produce more or less itching. I first treated her with sulphur and vaseline, one drachm to the ounce, when the disease seemed to improve, but it is uncured. Thursday I gave her four grains of the bi-chloride of mercury to an ounce of equal parts of alcohol and water. If this does not cure it, I shall raise it to ten grains to the ounce, so the treatment proves that there is quite extensive varieties of vegetable parasites and they are not always cured by the same remedy.

The treatment in this case has been through epilation and the employment of parasiticides. Epilation has been practiced daily. The hairs were loose and easily extracted. The parasiticide used immediately after the epilation. The crusts have been soaked with tincture of green soap and hot water. An application of thymol dissolved in oil in ten per cent. strength to the hairy parts of the face has been used for the purpose of preventing the transmission of the disease to other parts. The parasiticide used after epilation, which has been used every day, is composed of bi-chloride of mercury four grains, alcohol half an ounce and water half ounce. The alcohol causes the absorption of the mercury into the deeper structures of the skin, where the parasites are principally imbedded. At night, before retiring, he bathes the face in a solution of boracic acid, then applies the yellow oxide of mercury four grains, sulphur precipitate drachms one, to vaseline ounces one, every night. The duration of the disease is uncertain as the parasites are so deeply imbedded in the subcutaneous tissues that we cannot be certain when they are all destroyed, but will probably take several months; but

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after they are once destroyed the disease is permanently cured. As the disease is a local one, no constitutional treatment is indicated. Lancing of the nodules is unnecessary.

When he first came to me, from the amount of swelling in the jaw and in the cervical glands, I was in doubt whether it was a tinea psychosis or not, and I questioned him in reference to his previous history, and he said that he had a diseased tooth which had caused some necrosis in the jaw bone, six months or a year previous to the appearance of the present eruption. The ray fungus is usually introduced into the system through an affected tooth and enters the tissues through this avenue; but, before his having treated the cattle his jaw had entirely healed up; but frequently there is many months between the introduction of the ray fungus into the tissues and their appearance in the forms of abscesses upon the surface. The microscope settled the diagnosis, that it was not ray fungus but the tinea meglasporon of Sabouraud. The large amount of swelling was the result of lancing the nodules and applications of tincture of iodine and carbolic acid, which had set up an unusual amount of inflammation. So far the treatment that I have pursued has been quite satisfactory, and the disease has been going along toward a favorable termination. I shall continue to examine the scales and epilated hair under the microscope from time to time until the spores cease to make their appearance.

DISCUSSION.

In response to a question, Dr. McVey stated that the spores were not found in the pus, of which there was but a very minute quantity. They were found adhering to the roots of the hair, as it was drawn out, and could be brought to view by a microscope magnifying 350 diameters.

Dr. Hughes: I do not see the objection to incising. I think there is less liability to produce scars with incision and antisepsis. If you do not incise, there is danger of the spores extending to uninfected areas. I regard the treatment by bichloride in alcohol solution excellent. But I think the scar is apt to be less with cutting than without.

Dr. Davis: I can perhaps answer Dr. Hughes' question by a hypothetical case. Consider this simply as a case of ringworm, which is found in various portions of the body. In children it is found on the scalp. The ordinary attacks of ringworm upon the scalp arise from a fungus attacking the outer layer of the skin,

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and it is a superficial trouble. In some cases we find this tinea psychosis going deeper, following the hair follicles. In some cases the abscess is simulated by tinea kerion. On incising there is no pus there. In such a case of ringworm you do not want to incise it, to leave a scar. The idea is not to open the wound to any outside infection. If you were to look at this under the microscope, you would see not only spores but mycelium. This case that we have here is really and truly barber's itch, which may mean anything.

Dr. B. D. Eastman, Topeka, Kas., read a paper on "Insanity as a Defense in Criminal Cases."

There are five points of view from which insanity as a defense in criminal cases will be considered.

1. The judicial.
2. The medical.
3. The popular.
4. The individual.
5. The expert.

The Judicial View.—Knowledge of right and wrong is the judicial test as to responsibility for crime. Every person by the common law, is supposed to be sane and responsible unless the contrary is shown by the party pleading insanity as a defense. To make it a successful defense, insanity must be shown to be the result of disease either congenital or acquired and to be of such extent as to destroy the power of distinguishing between right and wrong as to the particular act in question. It is not sufficient to claim that the accused has been impelled to commit crime, but he must be unable to discover or appreciate his legal and moral duty regarding the act in question. Indeed, as to moral influences compelling to crime the bench has laid down the dictum, "Every crime was committed under an influence of such a description; and the object of the law was to compel people to control these influences." (Rolf. B. in *Rogers vs. Hemet.*) Judge Cox in his charge to the jury in the Guiteau case said, "An irresponsibly insane man can no more commit murder than a sane man can do so without killing. His condition of mind cannot be separated from the act. If he is laboring under disease of the mental faculties, if this is a proper expression, to such an extent that he does not know what he is doing, or does not know that it is wrong, then he is wanting in that sound memory and discretion which make part of the definition of

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murder." The judge further states that if insanity be established to the degree which may be called total insanity, the defense is perfect. But it is in the so-called cases of partial insanity (for want of a better term) that difficulty arises. For a person afflicted with so-called partial insanity may commit offenses with which his infirmity has nothing to do; or he may commit a criminal act the nature and consequences of which he fully understands and to the doing of which he is led by the same considerations that ordinarily govern in such cases.

Time will not allow an extended reference to judicial utterances on this question, and while the dictum laid down in the celebrated McNaughten case, that knowledge of right and wrong determines responsibility, has been somewhat mitigated in recent years, it still constitutes the substantial basis of judicial utterance.

The Medical View.—Many medical writers hold to the view that whenever there is any mental disease the party is entirely irresponsible, and insist that there is no distinction between medical insanity and "legal insanity." On this subject Spitzka says, "On some occasion the question of defining what is called 'legal insanity' may be presented to the reader of these lines. When that question is asked, he may safely challenge the questioner to show him a broken leg or a case of small-pox in a hospital ward which is not a broken leg or a case of small-pox in law; to show him a tumor or a softening of the brain, which is meningitis or sclerosis in law, or to define the conditions under which any disease-symptom becomes an indication of health. When these conditions are complied with, and not till then, may the physician attempt to define 'insanity in law' as distinguished from insanity in science. In the meantime he may rest contented with the dictum of one of the best legal authorities that that cannot be sanity in law which is insanity in science, just as nothing can be a fact in science and a fiction in law at one and the same time."

But there is a growing tendency among psychiatrists to look upon this view as too extreme to meet the practical every day requirements. Theoretically, every person who is mentally diseased in any degree is of unsound mind just as every one who is affected with any physical infirmity is of unsound body. But a person may fall short of perfect soundness of body and not be incapacitated for general physical activity. It may be only when his infirmity is brought in contact with a certain class or stand-

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ard of material demands that his physical impairment becomes manifest and he exhibits physical incapacity. A broken leg is a broken leg both in medicine and law, but a medically diseased leg need not be a legally useless one.

There is no question that in cases of total insanity (as expressed by Judge Cox) there is total irresponsibility. It is in those cases which lie along the border line between sanity and insanity, and when at times the mind may be controlled by ordinary considerations, and at others be under the sway of unusual, morbid, irrational impulses, that doubt and difficulty arise. Just as bodily disease may exist to an extent which requires medical treatment but does not incapacitate for most of the ordinary physical responsibilities, so there may be a limited mental impairment which demands medical treatment, but does not ordinarily incapacitate for most of the moral responsibilities. It is only when some unusual psychic demand is made that mental incapacity is clearly manifested. The border land of insanity, the debatable ground between complete responsibility and clearly admitted irresponsibility, is a broad strip with ill defined, irregular, ever-shifting boundaries.

The Popular View.—The popular view is variable, volatile and impulsive. It is as likely to err one way as the other. In a well marked case of total and previously recognized insanity, the popular view will generally be correct, but in other cases the public may jump at a conclusion that will be erroneous. In the one case the popular verdict may hold the perpetrator sane and responsible because insanity has not been publicly manifested, when in fact, it undoubtedly exists; in another case atrocity is held to show insanity, when every indication points to deliberate, predetermined, responsible action. Such conclusions depend often upon the confounding of the unnatural condition which generally determines criminal acts, with an irresponsible one due to disease. Thus, in a case or alleged patricide, the atrocious circumstances led many to say, if the party charged therewith committed the act, he must have been insane, when the circumstances were such, that an admission that the act was committed as charged, necessarily carried with it an admission that the party accused thoroughly comprehended the nature and consequences of his act and had sought to avoid the consequences to himself by aid of an intermediary.

Another phase of the popular view which not unfrequently ways a jury in deciding upon a verdict is in reality, simply a sen-

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timental justification of the act in question, as when a man wreaks his vengeance on the despoiler of his home or seducer of his daughter.

The Individual View.—When a person has been arraigned for the commission of a serious crime, homicide for instance, for which he has no other defense, his friends, his lawyer and frequently he himself turn to insanity. It is all at once brought out that he has been subject to "spells" and whether these "spells" be actual attacks of insanity or epilepsy or are due to drink, to violent, unrestrained temper or to inherent viciousness, they are made to do duty as indicative of irresponsibility. In this way much discredit is brought upon the legitimate use of insanity as a defense. The rule is that the really insane do not admit their insanity.

The Expert View.—These different views of insanity come more or less in conflict whenever insanity is alleged as a defense in any criminal trial. The end and aim of judicial procedure is, or should be, to arrive at the truth. One of the methods by which it is sought in criminal trials to aid the jury in determining the sanity or insanity of the accused is the expert witness. The proper function of the expert is to enlighten the court; counsel often attempt to use the expert to confound the jury.

The great difficulty with which the expert witness has to contend and which often misleads and confuses the jurors or induces them to ignore his testimony, is that he is selected or "called," as it is termed, in the interest of one side. He becomes, often unconsciously, amalgamated to the side which calls him and being obliged to give his testimony in answer to a shrewdly formulated hypothetical question, he is prevented from giving the jury and court the assistance which it should be his proper function to render.

Various methods have been suggested as likely to enhance the real value of expert testimony and still preserve the rights of each party. In my opinion, the best way to secure competent unbiased helpful expert testimony would be a provision of law authorizing the judge in every case where insanity is alleged as a defense, to appoint one or more experts to thoroughly examine the case and report their finding to the court. Such experts would, like the judge, be impartial, would seek to ascertain the truth and, like the judge should be paid by the State, a reasonable compensation irrespective of their finding. Such finding would be what all expert testimony ought to be, a genuine expert aid to the court.

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The finding should contain the facts upon which it is founded and explain the meaning of such facts, and counsel should be allowed to introduce testimony as to the correctness of these alleged facts and to cross examine the experts as to their interpretation of alleged facts and their bearing upon the case. The experts should be allowed to fully explain their opinions, but the distorted hypothetical question and the badgering, often ridiculous, cross-examination should not be allowed. It may be claimed that in order to accomplish these results changes in our laws would be requisite—then let us have the changes.

Dr. Ida C. Barnes, Topeka, Kansas, read a paper on "Rectal Alimentation."

In presenting this topic, I have no hope of adding anything new to the literature already extant; but rather to discuss with the members of this Society the advisability of early attention to this method of feeding, in those cases of acute disease, in which there is early irritability of the stomach and inability to digest food or power even of retention, also when predigested food cannot be kept upon the stomach in even small quantities, and the nourishment is in danger of failing.

All physicians recognize the fact, that much of the irritability of the alimentary tract is due to improper food and the overloading of the stomach, and appreciate the need of fasting in those cases, and of course this method is not then applicable; but I refer particularly to all diseases in which malnutrition is present and is due from whatever cause, to inability of the stomach to digest and absorb the needed nourishment.

As to the length of time that the rectum can be relied upon to absorb nutrient material without irritation depends upon the peculiarity of the individual case, and the care taken to prevent abrasion with the nozzle of the syringe as well as of proper manipulation of the fluid injected, that it shall not press upon the anal sphincter, and likewise that a proper quantity be used.

All will testify to the common experience, that we are prone to fall into routine channels, and often, when called to see a very sick patient and find that the stomach will not retain food, we are tempted to give it a little more rest by ordering less food or a fast and let the patient suffer the consequences, forgetting how an all day fast, for a well person with good nutrition, produces discomfort and disability and loss of tone, then how much more, the patient with fever—who is destroying more cells and creating

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more waste-products, than the hardest day's labor could possibly accomplish.

We of course expect later to bring up the nutrition, and usually can, but the question is, are we justified in waiting, and may not the equilibrium of resistance to the invasion of germs be lost at the moment that we leave our trenches unguarded.

It is unnecessary to remind the members of this Society that the rectum must be prepared for its supplemental work by a thorough cleansing of the alimentary tract and that by proper laxatives and the washing of the rectum and the lower bowel with full enemas of warm water containing a little salt, or soap and water.

There has been much question concerning the proper amount of liquid nutrient to be used, and how often repeated, also in what form best taken.

I have had the most experience with milk, and this of course should be predigested. This is most easily accomplished by instructing the patient to get a box of "Fairchild's" peptonizing tubes and follow their directions for the warm preparation.

If beef juice or eggs are used they ought also to be predigested, for the rectum and lower bowel is not primarily an organ of digestion and does well when even a partial supplementary power is acquired, in a measure, for a time.

With regard to quantity, the most evidence is in favor of about four ounces every four hours, although larger feedings are growing in use. I feel very confident that after all precautionary means are used to procure a nonirritable rectum, and that when the nutritive enema is given the hips are elevated considerably, that the prospect of retention with comfort and in large quanities is possible.

In addition to this possibility of feeding, medication can be added at the same time, and all medicines that are compatible can be given in the same feeding and with a disregard for taste, which to say the least, is most gratifying to both the patient and the physician.

Occasionally the enema of milk, when a little large, will cause gaseous distension of the bowels from fermentation and is attended by spasmodic colic.

This is usually easily relieved by inserting the nozzle of the syringe, unattached, into the rectum and leaving it in position for an hour or more through which the gas and a small portion of the milk and liquid feces will escape and give relief.

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I believe that when rectal feeding is necessary that stimulation added to the feeding always secures the best results by bringing up the general tone until the desire for food will enable the stomach to retain nourishment in small quantities at least.

Some diseases as cancer of the stomach receive but little benefit except to prolong the life of an incurable patient for a short time, and perhaps make more comfortable.

In ulcer of the stomach rectal feeding gives the quiet rest needed and may be prolonged a week or more, in accordance with the severity of the lesion.

Cases of acute gastritis are amenable to this treatment.

It is often surprising how quickly patients adapt themselves to this method of feeding—sometimes with good grace and at other times grudgingly, but with good results.

One of the most peculiar cases that I have ever met, was a child of two and a half years, who, while showing but slight symptoms of irritation and none of the stomach, as far as we could ascertain, except a slight distension of the abdomen, and with but a degree or two of rise of temperature at irregular intervals, suddenly refused to eat or drink milk, the latter being her principal diet. This she persisted in, although evidently losing strength and giving up active exercises. She would occasionally ask for different articles of food and then only take a bite or refuse to taste even, when brought to her. She drank water freely. After a vain endeavor to induce her to take milk, thinking she would eat in a day or two, I counseled patience and put her upon calomel and soda tablets which she took in water.

Persisting in the refusal of food and beginning to show a lack of nutrition, I prescribed rectal feeding, four ounces of predigested milk every four hours. This was given regularly, with a small amount of whisky in it, for a week when all at once she called for milk, and much to the delight of her parents drank about half of the usual quantity with eagerness. We kept her on half diet for a few days and then she went back to her original diet. She was an artificially fed child.

About three months after, however, she was taken with croupous pneumonia, and again refused to take food by mouth and was too seriously sick to be forced, so we returned to the rectal feedings with a liberal amount of stimulation in the shape of whisky, sulphate of strychnine, quinine, and digitalis given in the predigested milk every four hours with carbonate of ammonia dissolved in water by mouth, which she never refused. At her lowest

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period whisky and quinine were given in addition in a little milk between the regular feedings by rectum. Just before these stimulating enemas she would grow very restless and become very much depressed, but as soon as they were given, was quiet and restful and usually went to sleep.

She was carried entirely through the two weeks of pneumonia upon rectal feedings alone. The crisis did not come until the twelfth day, the temperature varying, much of the time at one hundred and four and one hundred and four and a half.

During the latter part of the second week she was very depressed and feeble. When she began to get better she called for milk, and she seemed to have no trouble in digesting it; but until she gets ready to eat she absolutely refuses everything in the shape of food by mouth.

In this case there was never any trouble with rectal irritation and she rarely failed to keep the enema.

It has always been a question in my own mind, whether, if I had not had the former experience with the child, I would not have delayed the rectal feeding long enough to have seriously endangered the chance of recovering, if at all, in the pneumonia attack; also the previous experience of the mother who took care of her through both attacks, was undoubtedly of the greatest value in the more serious disease.

In the emesis of pregnancy in conjunction with all other means of relief for the reflex uterine irritation, rectal feeding will often tide over the period of greatest irritability and sufficiently supplement the small amount of nourishment taken by stomach, to secure the needed sustenance and strength until with the ending of the fourth month and the rise of the uterus in the abdomen, the emesis will usually diminish and gradually disappear. There are exceptional cases in which even this method fails, depending as it does upon so many contingent circumstances; and yet when faithfully tried the physician feels that another measure for the saving and prolonging of life has been used.

Very recently I have had a patient under my care who is suffering from a localized colitis of some three years standing. The coating on the tongue was thick and noxious. The patient has likewise a chronic gastritic metritis and rhinitis.

The abdomen has been concave in outline, so much so, that she pads to relieve the unnatural depression and she passes large mucus casts of the bowel. She is hysterical in temperament. With all this list of ailments there is no necessity of announcing that

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she is extremely miserable and that the digestion is insufficient for proper nourishment.

She takes milk fairly well by mouth, but does not succeed in living with comfort upon it exclusively for any great length of time. About two months ago I concluded to try cotton-seed oil in rectal injections, to be given after going to bed at night and retained until the next morning. This she succeeds with remarkably well taking a pint every night and absorbing a large portion of it.

She is looking and feeling very much better and is so pleased with the method of treatment that she is very glad to continue it indefinitely until at least her health is very much better.

The mucus casts of bowel have lessened much in size as well as quantity.

It is only fair to say that another patient in much the same condition failed to retain the oil at all; but perhaps she did not give it a faithful trial under the most favorable conditions.

The fact that a pint or more of saline solution supplies the needed fluid to the system in this case of irritable stomach, where even water is not retained and after surgical operation, where the anæsthesia again prohibits fluids by mouth, must not be overlooked, as likewise, that even in larger quantities it may in a measure supply the loss of a serious hemorrhage.

My only plea in this short paper is for that conservatism which shall ever be on the alert, at the earliest moment, to guard against failing strength by the use of every means to secure sufficient nourishment, as well as to say that not only loss of life but that which is often of greater importance to the sick, much comfort can be secured by the employment of this method in proper cases.

Dr. H. L. Alkire, Topeka, Kansas, read a paper on "Granular Lids."

Mr. President and Members of the Society: When thinking what I could or should present, as an oculist, that would be of most use to the general practitioner, I tried to avoid any subject that would be so oculistic as to be tiresome. Of all the eye diseases that come to you for treatment, probably none are more common, or more troublesome to treat, than granular lids. Possibly I should apologize for resurrecting a subject as old as the pyramids of ancient Egypt, one which has engaged the attention of every generation since the early dawn of human history, down to the present.

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But so long as trachoma continues to rage with such injurious results and is treated with such poor success, by both the specialist and practitioner, I believe it is well for us in our onward rush, to pause occasionally and see from what sources we may collect useful assistance in treating some of these very aged diseases; and especially, should the specialist do this, for he is very liable to become so dazzled by some of the more brilliant achievements of his special line, that he neglects other duties just as important.

He should be careful, lest he draw the boundary line of specialism so closely as to make himself a localist, instead of a doctor of medicine. He should not only be familiar with the special organs he treats, but he should also be familiar with the entire body, the relationship that each organ in health and disease bears to all parts of the body.

Man, the masterpiece of the great architect of the universe, is so wonderfully constructed, each organ so intimately related through the nervous, sanguiniferous and lymphatic systems, that anyone, failing in the proper performance of its functions, may seriously impair the vitality and functions of other organs.

Consequently, our success as physicians or specialists, must depend largely upon our ability to detect and correct abnormal conditions in all parts of the body.

The doctor who treats cases of trachoma by carelessly applying cupri sulphas and argenti nitras, is very soon going to accept the popular prognosis—that trachoma is an incurable disease.

Volumes have been written concerning the causation of trachoma; some claim the exciting cause to be a small diplococcus; others, equally accurate, claim this organism does not stand the crucial test of inoculation.

While it may be quite impossible to isolate one germ and prove to the entire satisfaction of all, that it alone is the cause of trachoma, yet, we have learned much positive and valuable knowledge from clinical experience and laboratory research.

History of trachoma informs us, and clinical observation proves to us, that its greatest field of activity is among those who are most exposed to debilitating influences and irritating causes tending to produce conjunctival hyperemia or catarrh.

Trachoma, like many other diseases, must find favorable soil before it can develop. It being true that trachoma is an infectious disease, the presence of which is invited and favored by a

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lowered state of vitality, the indications for treatment are plain and may be summed up as follows:

1. Absolute cleanliness and good hygienic surroundings.
2. Improve, if possible, the nutrition of the body by correcting the existing abnormal conditions.
3. Remove the trachoma bodies, and keep the eye clean as possible by use of antiseptic solutions.
4. Correct the refractive errors.
5. Treat sequelæ—according to its nature and indications.

The majority of trachoma cases with which I have had to deal, presented various forms of constitutional derangements; prominent among which were gastro-intestinal disorders, rheumatism, hepatic and renal troubles.

To obtain a healthy process of repair in the conjunctivæ it is quite necessary to aid the local treatment by correcting the existing constitutional or local troubles affecting the nutrition of the body and indirectly that of the conjunctivæ.

Knowing that a long report of cases would be very tiresome, I will only take the liberty of reporting two or three illustrative cases.

CASE 1.—Chas. B., age 55, looks to be 70; an old soldier; Dec. 28, '96, was brought to our office, complaining of intense pain in each eye, photophobia and failing vision.

Examination of Eyes—Lids: thickened, deformed, inflamed; celia: few and short; conjunctivæ: tarsal portion covered with scars and inflammatory patches; retro-tarsal portion thickened, inflamed, covered with trachoma bodies; ocular portion inflamed; cornea: R. E. Sup. ¼ ulcerated; L. E. Sup. ¼ ulcerated.

History of exposure, neuralgia, rheumatism, kidney trouble, etc.

Present Condition.—Teeth decayed, appetite poor, dyspepsia, constipated, urine highly colored, scant, specific gravity 1030, strongly acid. Paralysis of sensation below knees.

Treatment.—Removed trachoma bodies by expression, irrigated with hydrargyri chloridi corrosive solution, 1-5000, and applied cold compresses. Prescribed phenacetin et salol tablets, grs. v., one every hour while in pain.

R. Potas citras.
Kali iodidi.
Essence pepsin.

R Cascara.

Plain diet, no meats. Daily local treatment consisted of corro-

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sive sublimate solution, argenti nitras, unguent, hydrargyri oxidi flavi.

Hot eye bath every three hours. Recovery uneventful. Patient discharged March 1st. Eyes free from trachoma and inflammation. Site of corneal ulcers marked by slight opacity. No glass improved vision.

CASE 2.—Mr. C., age 41; farmer; came to office complaining of pain and photophobia. History of continuous sore eyes since age of 22.

Examination.—Lids thickened and deformed; ciliæ thin; conjunctivæ, tarsal portion, scars; transitional portion, few trachoma bodies; corneæ: R. E. ext. ½; covered with superficial ulcer. L. E.—Cornea clear. Left cornea clear.

R Potas. iodidi.
Hydrargyri chlor. cor.
Syr. trifol. comp.

Plain diet. Daily local treatment same as No. 1.

R Kali iodidi.
Hydrargyri chlor.
Syrup trifolium.

CASE 3.—R., painter, complaining of sore eyes; general health good.

History—One year ago contracted an eye disease by using some towels that another person with sore eyes had used. Been treated by other specialists; general health fair; kidneys sluggish; urine, high colored and specific gravity 1030.

Examination—Trachomatous; conjunctivitis.

Local treatment same as before mentioned. A plain diet.

R Kali iodidi.
Hydrargyri chlor.
Syrup trifolum.

R Potas cit.
Infus. Buchu, qs.

July 29, eyes O.K. Recovery uneventful. Other treatment same as case No. 1.

DISCUSSION.

Dr. R. E. McVey: If there is no syphilitic taint, I don't see what call there is for constitutional treatment. I do not see what the doctor's objection is to sulphate of copper. I have treated such diseases many years with sulphate of copper, and with suc-

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cess. A man came to my office a few days since who had been treated by specialists, until his money was all expended, and now he is nearly blind. I am using bismuth and rose ointment, and his eyes are getting a little better. He has no money now, and I would like to find out how to cure him as rapidly as possible. Will the doctor please state the objection to sulphate of copper?

Dr. Alkire: I endeavored in the paper to explain why it is necessary to give constitutional treatment, because the eye is just as much a part of the body as any other organ. The disease is a local disease, but as in the case of many other local diseases, to get the best results it is necessary to have the body in the best possible condition. Although the disease may be local, it is far better to have a perfectly healthy body to treat if possible, and so many of these cases that I have seen are those of persons who are in a weakened and debilitated condition. Although it is a local disease, if there are diseased conditions elsewhere they will retard the action of remedies so that the results of the local treatment will not be satisfactory. Sulphate of copper has a useful place in treating these diseases, but not nearly so useful as some others. One object in the treatment of trachoma is cleanliness, and we can secure that by using some other means and keeping the eye clean. The way sulphate of copper is generally used it were better not to apply it at all. So many use it for caustic purposes, and I have seen eyes injured by the use of sulphate of copper, and so also nitrate of silver. I have seen eyes injured by its use, and have got better results by using other and antiseptic treatment, and am especially fond of corrosive sublimate. Hot water can be used to the extent that it may be injurious. I would use corrosive sublimate one to five thousand. Keep the conjunctival sac clean and you will get good results. If you simply open the eye and evert the lid and go to squirting some solution into the eye, you might as well omit it, for the result is not cleansing at all. It is necessary to cleanse the whole conjunctival surface, as it is in cleansing anything else.

Dr. Gill: I would emphasize the matter of looking after the general condition of the system. I have surpassed my neighbors over and over again, when their local treatment was perhaps just as good as mine.

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Dr. B. S. Stewart, Netawaka, Kas., read a paper on "The Need of Medical Legislation in Kansas."

Years ago, I heard a man say. "If I had three sons and each should ask me to choose his occupation for him, I would make a lawyer of the greatest rascal, a doctor of the biggest fool, and a farmer of the most intelligent." *Then*, this speech, uttered by a wise, thinking, observant man, made little impression upon me, but in these latter years, it has recurred to me again and again, andmuch of significance attaches to it.

People in general form their opinions from their experience, experience growing out of their environments, their contact with the material world about them. This man had evidently reached his conclusion through an inductive process of reasoning: "Dr. Jones is mentally weak, Dr. Smith is below the average and Dr. Brown is a fool; therefore, it requires little intellect to prepare for the practice of medicine."

The fact is, his reasoning was false from beginning to end, his knowledge of the profession of medicine being too limited to permit of a correct result through this logical process. Had his environments been different, had he spent his life in New York City where the brainiest, most learned men of the metropolis are its doctors of medicine, he would have arrived at an entirely different conclusion, and no doubt would have formulated his impressions thus: "I find great difficulty in selecting professions for my sons. I was anxious for one to study medicine, but none of them have brains enough; life is too short and the field of medicine too broad for an ordinary intellect to make much more than a beginning along that line."

But the existing condition that led this man to his erroneous belief is too common within the United States to be treated lightly; the fact is, it is one of the most serious, momentous questions before the public to-day, notwithstanding the disregard with which it has been, and is, treated by our lawmaking bodies. It is all very well for us to look around and see others served by a mediocrist in this capacity, but when we, ourselves, are brought face to face with death, a greater importance attaches and we want the very best skill and the highest order of intellect brought to our assistance.

When people desire to place the very strongest possible emphasis upon any particular subject, they refer to it as *a matter of life*

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and death, when the truth is, this peculiarly emphatic expression may be justly applied to the majority of cases that fall into a doctor's hands for treatment. When we consider the extremely vital nature of the question at issue, its unequivocal importance becomes plainly apparent.

The older States in the Union have long since recognized the necessity for medical legislation and have enacted laws extending, limiting or otherwise modifying the rights of the practitioner as was deemed best for the highest welfare of their citizens. But strange to say, our own State, otherwise progressive and standing shoulder to shoulder with her sister commonwealths, has, thus far, taken no decided action regarding the matter, which leaves our doors open to the unqualified that have been debarred elsewhere.

In different States, the laws controling the right to practice medicine differ, some making the standard much higher than others; and in the older countries of Europe we find them much higher than any that exist here in our younger nation. Take France for example, where the requirements by law are such that comparatively few ever attain to that degree of knowledge and skill necessary to actual practice; and the result is, where there is one doctor in France there are a dozen or more in the United States. This only goes to show that as civilization advances, the standard of our profession is elevated, and the day is not far distant when Kansas will be compelled to fall into the procession.

In some other States, when a man fails in business or loses a job, he goes into the insurance business; here he hangs out his shingle with a very prominent M. D. following his name, and if it succeeds in attracting patients, he practices medicine, while the lawmakers are so busy with other matters they have no time to interfere.

Aside from the fraud practiced and the resulting ill to the people in general, the profession itself is injured by this lack of legislation. For a man who has spent years in laborious research to be placed upon an equal footing with a raw, untutored saw-bones is flagrantly unjust; and many who are skilled in both the science and the practice hesitate to enter a State where such injustice prevails. Thus it is that the profession has suffered and has come to be calumniated because of the numerous unqualified individuals who, finding nothing to exclude them, impose upon the public for the sake of the few dollars it turns into their pockets.

That Kansas needs medical legislation is a truth too self-evi-

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dent to require proof or to admit of argument even; but just what that legislation should be is "another story" as Kipling would say. No one that has given the subject a modicum of thought, no matter what his school of medicine or be he layman, will deny that it is inhuman to place the care of the sick in the hands of one incapable of making a correct diagnosis, or too ignorant to prescribe the proper remedies should the disease be known; but as the situation exists to-day, there is no way of distinguishing the man of proficiency from the impostor, and the first step should be to establish some means by which the first class may be given proper recognition, while at the same time it excludes the latter.

If we would practice economy and borrow the experience of other States in correcting this arrant imposition upon one of the highest existing professions, as well as upon the public, the most effectual method seems to be the erecting of a standard of excellence and the enactment of a statute compelling all who enter the profession to be measured thereby. In other words, a diploma from some reputable school of medicine should be the qualified man's passport into the medical fraternity. Just what institutions are worthy of recognition in granting these certificates it should be the part of our legislature to determine. But just what that legislation should be does not lie within the province of my subject. There is also another most important phase of the question hinging closely upon this one, *how to secure medical legislation in Kansas.* It is conceded by all thinking people who desire to promote public welfare that we need it, and now the problem for solution is, *how to bring it about.* Evidently, it must come through the medical profession itself, since that body, more than any other class of people, sees and recognizes the paramount necessity of taking some decided action upon the matter. One of the questions that each member of this association should take home with him for solution is this one of how to secure medical legislation within the borders of our great and rapidly developing commonwealth; so that in the near future we may bring such intelligent pressure to bear upon our legislature that without further delay they will give us what we ask.

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Dr. W. S. Lindsay, Topeka, Kas., read a paper on "Thyroid Therapy."

The idea of transferring the finished product of the much studied and still mysterious organ, the thyroid body, with its accessory glands, from lower animals to man, does not carry with it to our minds the name of any individual. This phenomenon as remarkable and definite within its limits as vaccination, will not be mentioned in our resumes of the advancement in medicine with an immortal discoverer, from the fact that it was the outgrowth of the studies and researches of several. King, of London, showed over one hundred years ago that the colloid substance of the thyroid gland passed directly into the lymphatics. Schiff, Kocher, Murry, Ord, Brown-Sequard, who was made sport of through the daily press, along with Oliver, Schaffer, Horsley, and others, directed attention to the glandular structures as the producers of the elements controlling metabolism. This opened the gate to a field which has been assiduously cultivated and with a fair yield in return.

A remedy that does with certainty control the tissue metamorphosis theoretically, comprehends more that is to be desired in a remedial way. The water of the spring of perpetual youth can have no greater efficacy.

Being heralded as possessing this basic quality it is not surprising that thyroid therapy received almost universal application.

Credible observers have reported clinical evidence to support much that might be included in this comprehensive use of the remedy.

Increased appetite with more complete absorption of nitrogenous foods, growth of the skeleton of the young, marked improvement in general bodily nutrition, increased activity of mucous membranes, skin and kidneys, and greatest of all, increased metabolism of brain cells have all been reported as resulting from the administration of this organic complex the active ingredient of which, the colloid material, contains iodine-thyroiodine which is thought by Baumam and others to be the really essential element. If this be true it furnishes an interesting evidence of the wise selection of remedies by our forefathers in medicine.

Like the germicidal quality of mercury and the destructive effect of the products of Peruvian bark on the plasmodium of Lavaran, we find on opening the husk, the kernel which reveals the rationale of old therapeutic principles.

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These are, however, only gleams of light as far as the thyroid is concerned, for there are still several conflicting points in evidence. The apparent need of a continuous supply of thyroid product in the economy of our bodies is contradicted by the removal of the gland without apparent detriment for more than a year.

Much more is known and believed to be true regarding thyroid uses than I shall attempt to collate. Following these known and reasonably rational lines, many diseases have been treated by thyroids—rachitis, skin diseases, myxedema, cretinism, muscular atrophy, epilepsy, diabetes, and the various insanities, being prominent.

My own experience includes the following cases. My first case was one of myxedema occuring Dec. 1895, the treatment being carried out by Dr. Marner, of Marion, who reported the case in detail to this society May, 1896, at the Atchison meeting. This was an uncomplicated case making a rapid recovery and still remaining well, but I understand still requiring to continue the use of thyroid. I have used the powder in several cases of epilepsy and without effect so far as the convulsions were concerned except in one case. This was a girl about sixteen years old, who had apparently idiopathic epilepsy, the attacks occuring several times a day. The mind was disturbed to the extent of grossness of manners, incorrigibility, untidiness and inability to continue in school.

The skin was coarse, the mould heavy, and withal there was the general appearance of imbecility.

Treatment consisted of six grains of thyroid powder per day and within one week the epileptic seizures discontinued with no more return for nearly six months. During this time the mental condition changed so that the girl went to school and assisted her mother in household work.

Two weeks ago a severe convulsion occured at the menstrual period. The treatment is still continued, but I feel apprehensive that it will in the end be ineffectual.

Another case was one of myxedema with mental depression bordering on melancholia. The patient was a married lady and she began to worry, feeling that she was not equal in a social and intellectual way with her husband's sisters. The usual symptoms of myxedema were present and the history showed that a goitre had existed fifteen years previously and that this had been successfully treated with iodide.

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Increasing doses of P. D. & Co's Thyroid ex. from six to fifteen grains per day relieved the myxedema and melancholy within one month—the patient remaining well on small doses.

Another case was a girl of eighteen years, a primary dementia. There was gross untidiness of person, aimless resistance to anything that was done for her, requiring the constant care of an attendant. The history of this case showed infantile convulsions and later an attack of meningitis.

As a child she had learned slowly, but had gotten on fairly well until about one year previous to my seeing her. I felt that there was very little hope of benefit in treatment, but as there was the coarse appearnace of the face and general sthenic condition, I prescribed the thyroid, five grains three times a day. The patient lived out of town and I did not see her for one month when she returned entirely changed, tidy in person, quite normal in manners. She talked coherently and seemed restored. Three months later I heard from her, when she continued well.

I have a case of progressive muscular atrophy under treatment with the thyroid but the time is too short to make a report of any value.

I may also say that I have treated several cases of cretinism with some degree of success. I appreciate that what I have offered to you is nothing more than what I see reported from time to time in medical journals in regard to the usefulness of the thyroid extract. But I feel called to add my contribution of personal experience.

DISCUSSION.

Dr. Boyle: I want to say that I am glad that Dr. Lindsay presented the paper, and referring to his closing words in the form of an apology, I do not think it always the very rare cases that interest us most. It is the common everyday remedies and the common everyday subjects that we are most interested in. I have had samples of thyroid extract, but I have not up to this time had any occasion to use them rather than other remedies. But I am very glad to have heard this paper, and I do not think it is worth while to always try to present something rare but give practical matters. In this connection I am surprised that we have had no paper in recent years on diphtheria. Think Dr. Lindsay's practical and useful.

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Dr. H. M. Ochiltree, Haddam, Kansas, read a paper entitled "A Reply to Mrs. Mary G. Eddy."

In the Topeka *Capital* of January 1, 1899, appears an article by Mary Baker G. Eddy, defending Christian Science, in reply to one published in the *New York Sun* which assails that grotesque philosophy.

As Mrs. Eddy in this article challenges the world to refute her statements, I humbly submit a few ideas to controvert her sophistries.

Mingled feelings of amusement, pity and disgust possesses the physician when he contemplates the phantasmagoria of Christian Science so-called. By physicians generally it is considered derogatory to the dignity of their profession to come before the public in opposition to the chimerical fancies of this bizarre class; but it was only opposition that stemmed the tide of witch craft and kindred manias, and it is as necessary for physicians to array themselves in opposition to pestilential doctrines as well as pestilential diseases, for vagaries of the mind, like pestilential diseases, are contagious, and will spread unless stamped out.

In the early centuries our progenitors contended with the flaggellant and dancing manaias; later, with epidemics of alarm concerning the end of the world, with witchcraft, mesmerism, and spiritualism, and at the evening of the twentieth century we find the spectres of the tenth century delusions still haunting us draped in the gauzy folds of occultism and Christian Science.

This reply is not made in defense of scientific medicine. It needs no defense. It is made to help eradicate the pernicious effects of a superstition. Mrs. Eddy objects to the term "pests" applied by the *Sun* correspondent, because Paul was called a "pestilential" fellow, and since he did not prove to be one, ergo, Christian Scientists are not pests. This process of reasoning would justify every false doctrine that has ever been taught.

Why does Mrs. Eddy refer to Christ and Paul as exemplifiers of her faith? Christ raised the dead, gave sight to those born blind, cured leprosy, turned water into wine, and walked upon the sea. Can Christian Scientists do likewise? If she makes the plea that it was faith alone which caused these results, what kind of power was it that caused Elymus, the sorcerer, to be stricken with blindness for his malicious interference with Paul's work? Was it the faith of Elymus?

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Common sense says it was a *miraculous* power that wrought the cures of apostolic times, cures that never have been duplicated, and therefore were due to a power that no Christian Scientist will ever possess. The Christian Scientists presume when they class themselves with Christ and his apostles; but they can with good reason be graded with the Mormons, Spiritualists, Indian and African Voodoo doctors, as all of these can furnish thousands of testimonials that they have cured the same kind of affections the Christian Scientists cure.

Because Mrs. Eddy had scholarly men in her class in 1898 she therefore infers that the Christian Scientists are not "pests."

Are there not scholarly men among the Mormons, and the Diabolists of France? Are there not scholars behind prison bars? If so would Mormonism, Diabolism and crime be right?

She quotes the text, "Blessed are ye when men shall revile you, and say all manner of evil against you falsely, for my sake." Attempts have always been made by the advocates of false doctrines to weave a garment of sheeps clothing from the imaginary threads they have spun from this verse. Scripture tells us how imposters will attempt to climb the wall, and get in some other way than by the gate.

The gate of reason stands wide open, but you can't get a Christian Scientist to enter as long as he can climb.

Does opposition to certain theories prove them to be right? Slavery and the rum traffic are opposed, ergo right, would be the logical sequence of the metaphysics invented to protect Christian science. Mrs Eddy says she has "cured consumption". With all due deference to her, I beg leave to state that I can produce one hundred testimonials of consumption cured(?) by patent medicines, to one she can produce cured(?) by her method. She claims she has "healed carious bone." I will forfeit one hundred dollars to charity if she will cure caries of even a single tooth by her method. She makes the astonishing statement that she "healed at one visit a cancer." I will forfeit one hundred dollars to charity if she will even remove an inoffensive wart by her method.

I assume she was mistaken in her diagnosis, but in order to put her powers to a very reasonable test, I will select these simple affections, so easily relieved by ordinary doctors, from among her own apostles, in order to prevent the plea of "lack of faith" being made.

"By their fruits ye shall know them." She tells of a case of

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pneumonia she cured after the patient was supposed by a distinguished physician to be dying. Could not this physician have been mistaken? It is well known that doctors do err in diagnosis sometimes. They do not deny it. It is possible for a nervous affection commonly called hysteria, to so closely simulate real disease as to deceive even an educated physician occasionally. This is not surprising, as this affection has been deluding the charlatan for many ages.

The experience of physicians generally, and my own experience also leads me to conclude that Mrs. Eddy's case of pneumonia was most probably a case of mistaken diagnosis, and her apparent miracle one that can easily be duplicated on neurotic subjects by all classes of healers. But admitting that the diagnosis was right, and the patient believed to be dying, but recovering after Mrs. Eddy's treatment, yet this admission does not prove that her method was a factor in the cure.

For in Kansas alone there are two thousand physicians, all of whom have had, some time in their experience, patients whom they fully expected to die, but yet recovered even after all hope had been abandoned. In many of these cases, the patients, after having disposed of their effects calmly awaited the coming of the "grim monster," yet in spite of influences the most depressing, recovered their health.

Was it faith in these that cured, I would ask? The wildest imagination could not make such a claim. Or was it not the "*vis medicatrix natura*" a force which has operated since the creation of mankind, and which freely bestows its beneficent influences upon mankind without requiring faith. Let common sense answer.

I have no hesitancy in making this statement, and challenge contradiction, that, excepting diseases which would naturally recover without any kind of treatment whatever, the class of patients cured by Christian Science and its congeners belong to the hysterical, and have long been recognized and cured by the educated physician. Hysteria is an affection of the mind, so protean in its nature as to be difficult of detection except by the skillful physician.

Hysteria in a nut shell is *wrong thought*, having particular reference in this terse definition to morbid self examination. Wrong thought, or hysteria, can cause *affections* of the body, but not *diseases* of the body. Wrong thought, or hysteria, can cause contracted limbs, and cause one to be bedridden for years. But

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wrong thought does not possess creative power, and cannot create the *germ* of a disease, any more than wrong thought can create a cow or pig.

Nothing but *imaginative* affections of the body can be caused by thought. Real diseases come equally upon man, upon the unthinking animal, and upon the vegetable world, precluding the possibility of mental action being a factor in their production.

But wrong thought can simulate disease, frequently in a manner that would put to shame the histrionic art of our best actors. I do not deny that many hysterical patients have a predilection for, and are relieved by the faith healer; but I do deny the existence of divine, mysterious, or secret power of any kind in their cure. That which is miraculous to the faith healer and to the laity, is simple to the educated physician. Facts strip all cures of their mystery. Patients who are suddenly relieved do not have diseases of the body, but affections of the mind. It is madness, and it should by law be made criminal in this enlightened age, to attempt to cure bodily diseases due to germs for which volition is not responsible, by an act of the mind. But Mrs. Eddy denies the statement that Christian Science is limited to imaginary diseases, and to diseases that would recover without any treatment at all. Let her then submit her science, so-called, to a test, and demonstrate practically that she can cure as well as scientific physicians. We are willing to submit our methods to test conditions. Nothing can interfere with our cures, neither lack of faith, incantations charms, false belief, false gods, true gods or devils, and if we fail we are willing to attribute our failures to the right cause, to ignorance. and will not take refuge behind the cowardly plea of "lack of faith," or "dispensation of providence." Do not offer me *bona fide* testimonials of cures. Charlatans of all classes can furnish them by the car load for all kinds of diseases. They are absolutely unreliable. I therefore submit to Christian science the following tests: I will forfeit five hundred dollars to charity for a case of cancer or tape worm cured by any Christian scientist, under test conditions, providing, in case of failure they are willing to forfeit a like amount if scientific medicine effects a cure. I will forfeit five hundred dollars to charity if ten unvaccinated Christian Scientists will expose themselves to small pox if the usual number do not contract it, providing they will forfeit a like amount if ten protected by vaccination expose themselves, and do not take the

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disease. I will forfeit one-hundred dollars to charity for a simple case of "Kansas diggs" cured by Christian science methods, providing in case of failure they will contribute a similar amount in case any ordinary Kansas quack succeeds. "By their fruits ye shall know them." We are willing to show to the world the fruit of our knowledge by tests that will defy charlatanry.

A true science would grasp an opportunity to vindicate their claims in an open field; but what will the Christian Scientists do? They will dodge these trials, they will run from them, and hide behind some ignorant plea that may satisfy their deluded follows, but will not satisfy the "common sense" of the masses.

Mrs. Eddy does a great injustice to my homeopathic friends when she compares the cures effected by their efficient remedies to the vagaries of Christian Science. She says their medicines are so weak as to be ineffective, and that their cures are really caused by faith.

I will not presume to argue with her on the question of homeopathic potency. I will simply request any Christian Scientist to go into a homeopath's office with me, and swallow a vial of their *harmless* pills, and await one hour for results.

If I do not succeed in proving that homeopathic medicines will act on a Christian Science stomach, I will forfeit one-hundred dollars to charity. If I do, all I want the Christian Scientist to do is to pay the office boy for cleaning up.

Christian Scientists are no more successful as healers than the Mormons, mesmerists, spiritualists, or voodooists, all of which can justly claim more cures perhaps than Christian Science can, because these superstitions rank in age.

Which method, if any, is the right one?

The formula for the basis of all faith cures, is *suggestion* of some kind upon the part of the operator; upon the part of the patient, *concentrated* attention. Patients cannot be divested of their religious beliefs however false they may be; hence we find that cures are effected in the neurotic, whether they worship the true Christ or a false god, Mahomet or Joseph Smith, or have a superstitious belief in witches, spirits, magnetism, unnamed mystery, or Christian Science. When the world becomes better educated, Christian Science will occupy a curious place in history by the side of other supertitions.

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Dr. J. W. May, Kansas City, Kansas, read a paper on "Dermoid Tumor of the Conjunctiva and Cornea."

Mr. President, Ladies, and Gentlemen: I have selected this case for its rarity—a pathological condition seldom seen even by oculists of large experience. I have had cuts made showing the growth, and somewhat imperfectly the hairs in it. Mrs. Z., aged 30, was referred to me by my friend Dr. P. D. Hughes, Surgeon to Bethany Hospital, by whom she was treated for a more serious condition, namely, sarcoma, which will also be reported to this society by Dr. Hughes.

Figure 1 shows the growth of the right eye and figure 2 of the left, with the hairs growing from the center. These cases are al

FIG. 1.

ways congenital and benign, although in this case it is associated with a malignant growth in another and distant organ. "This congenital defect is frequently found associated with other congenital anomalies, viz.: hare-lip and wart-like appendages in front of the ears. The structure of these growths is practically same as the skin, containing hair follicles, sebaceous and sweat-glands." (Fuchs.) It is only a matter of speculation as to the development of a dermoid tumor in this locality, and hence we leave that part of the subject.

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FIG. 2.

In this case there was no disturbance of vision, irritation, or any other abnormality, which seems strange that hairs could grow from the eye-ball and cause no trouble.

The diagnosis is easy, as there is no other tumor quite similar, *i. e.*, a small yellowish growth in the conjunctiva, which may include the cornea. The hairs growing from it make diagnosis positive, but there are cases without the hair. The history as to its existence from birth is also a sure sign of dermoid tumor.

I recommended the removal of the tumors for the cosmetic effect; but she declined, as she had already sacrificed a large portion of her anatomy to another surgeon, and did not feel like decreasing her weight any further, even by a few grains, and, I think, rightly, as it was not progressing. When they are progressive and cause disturbance of vision we remove them, and usually without any danger, and with good results.

I have reported this case very briefly, as it could not be otherwise.

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Dr. J. W. Porter, Midway, Kas., read a paper on "Epidemic Cerebro-Spinal Meningitis—Observations in a Recent Epidemic."

In presenting this paper to the Society I shall, as the title indicates, confine myself to clinical observations and the lessons that may be deduced therefrom. Time will not permit the discussion of the etiology, pathology, etc.

This paper is based on reports of seventy-three cases, twenty-three of which came under my personal observation while four were reported to me by friends and parents of the patients. The other forty-six cases were kindly furnished me by the following medical friends: the Drs. Harvey of Pittsburg, 5 cases; Dr. E. O. Sloan of Pittsburg, 4 cases; Drs. A. O. Blair and Wm. Williams of Pittsburg, 11 cases; Dr. Gregg, of Chicopee, Kas., 8 cases; Dr. D. B. Colcord, Frontenac, Kas., 4 cases; Dr. C. A. Fisher, Pittsburg, 4 cases; Dr. J. G. Sandidge, Mulberry, Kas., 6 cases; Dr. O. F. Lewis, Hepler, Kas., 2 cases; Dr. H. H. Boyle, of Pittsburg, Kas., 2 cases. I have the grestest confidence in their judgment and honesty and sincerely thank them for their assistance.

On account of the positive indication of contagion in the first 10 cases in this series, as well as in two others, I shall report these cases as fully as possible.

CASE 1.—Age 22 years. Died without medical attention. The only history I could elicit was, that she had been sick three weeks with a fever and had complained of headache and general muscular and joint pains. Father seemed to know but little about her, and the mother was physically unable to tell.

CASE 2.—Mrs. R., aged 38. Mother of Case 1, prescribed for her Dec. 14th, '98, but did not see her. Husband told me she had had a severe chill the night before followed by a high fever, intense headache and persistent vomiting. Saw her Dec. 15th at noon. Temperature 102, pulse 70. She was crying with a pain which she said was "boring from front to back of head." Marked rigidity of the spinal column, more especially cervical portion. Turning or moving in bed caused intense pain. This rigidity and inability to turn without pain lasting throughout her sickness. Her temperature after three or four days fell to 100 and so remained except during the 2nd week when she had a chill on alternate days, followed for a short time with a temperature of 102½ to 103 and this was followed in a few hours by a sweating stage, thus simulating a tertian malarial fever. I ad-

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ministered quinine and after 4 or 5 days, chills ceased, and the temperature settled to 100 and 100½, and so remained until the end.

Her tongue at first moist, yellow central coat, with red margin, soon became dry, typhoid like, with sordes on teeth; but towards the close of 2nd week this condition improved.

Her respiration on several occasions were Cheyne-Stokes, especially marked towards the close. About the close of the 2nd week she picked at bed clothes and muttered. At this time she became quite deaf, especially in right ear which after a few days began to discharge a thin sanious matter. This condition continued though somewhat abated to the close. Her eyes were sensitive to light throughout. The action of heart at first corresponded with the temperature, though toward the close there was a decided weakening of the heart muscle and quickening of the pulse. For two or three days before death there had been an improvement of symptoms up to the evening before, when her respiration became decidedly irregular with what seemed to be a bronchial complication, death following in twelve hours. I was informed that just before her death severe contractions of limbs especially in the legs took place. Opisthotonous was increased. Convergent strabismus was observed and "purple and white spots" appeared on the body. Death occurred Jan 3, '99. Duration 21 days from initial chill. When I was called to Case 2, my attention was directed to Case 3.

CASE 3.—A two year old daughter of Case 2, who had been sick for 10 days, commencing with what her father thought was a chill, followed by fever, which had been more or less persistent, the child being very cross and irritable, often crying in its sleep. Father said it had for the past day or two laid in one position unless changed, and it seemed to dread being moved. I observed that its head was somewhat retracted, eyes closed as though to avoid light, while the expression of its face was somewhat dull; the least touch would arouse it, and the least movement of it would cause it to cry out. Its temperature was 203, bowels tympanic and constipated; pulse weak and rapid. My prognosis was unfavorable. This child died two days later with extreme contractions of right side, having been sick 12 days. As these cases were county charges, the sanitary condition can be imagined. All the children slept in a very small bed-room with the sister while sick, who I believe was infected with meningitis.

CASE 4.—Mr. D., age 78, saw him at 11 a.m. Dec. 24, '98.

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Found him in a condition of collapse, almost pulseless, absolute coma, no stertor, but some irregularities of respiration. Pupils moderately dilated. Non-responsive to light. Temperature subnormal. Extremities cold. Was informed that he had a violent "marrow freezing" chill 12 hours before with vomiting and cramping. As he was obviously so near death, I gave him a hypodermic injection of strychnia and left him, informing the family that he would live but a few hours. I expressed the opinion that he was suffering from the so-called "winter cholera of influenza." He died at 1:30 p.m. the same day, living about 15 hours after the initial chill. Subsequently I learned that while his vomiting had been persistent, his bowels had acted but two or three times, and that while attempting to go to stool, he had fallen into the unconscious condition in which I found him. The cramps were muscular spasms. He had also complained of headache.

That night I was called to see his aged wife who was suffering from nervous excitement. I found the single room, which has but a single half window, and was used for all household purposes, occupied by no fewer than 30 persons, the corpse resting at one end. I need not add that the air was exceedingly foul smelling. To avoid repetition, I will state that the next six cases remained in this foul smelling room during the night.

CASE 5.—Lottie D., age 11 years, grandson of Case 4, lived in same house. Saw him first Dec. 29, '99, at 9 p.m. Temperature 104, dilated pupils, slowly responded to light, pulse 100; considerable delirium. Semi-intelligence when spoken to; complained of headache; slight rigidity and tenderness of the spine.

History.—Came home from school the evening before complaining of stiffness of legs. At 11 o'clock that night (exactly 7 days after the initial chill of case 4) he had a chill followed by vomiting, high fever and three clonic convulsions. His temperature Friday morning had fallen to 102 and remained about this until the close. Near the end he had convergent strabismus of both eyes and decided rigidity. His respiration irregular, night terrors and violent delirium giving way to low muttering and final coma. The duration was 57 hours from initial chill.

CASE 6.—Mrs. D., daughter-in-law of Case 4. Saw her first and only time an hour after I saw Case 5.

History.—The night before she had a violent chill, followed by vomiting and an intense headache which she described as "tearing and boring." It seemed to pass back and forth from occiput

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to sinciput, causing her to scream. Her neck was decidedly rigid and drawn back, and the slightest movement of head caused great distress. Her pupils were moderately dilated. Eyes somewhat sensitive to light. She had a temperature of 100 although her pulse was but 40; skin moist and cool to touch. I warned her husband of her condition and advised him to secure another physician as they lived too far away for me to attend her. I learned from her relatives that she died nine days after initial chill.

CASE 7.—Thos. W., age 5 years, grandson of Case 4.

History.—Had chills December 30th, 31st and January 1st, about 10 a.m., of each day, each of which were followed by a severe headache and high fever, the headache following the last chill being especially severe. More or less rigidity of the neck from the first chill, on. Fever lasted but a few hours after chills, first and second, but after the third chill, fever was presistent, while attacks of headache increased in frequency and severity. During third chill, vomiting supervened and continued until January 4th, when I was called. He also had frequent night terrors. I found temperature 101, pulse 90; intensely dry, red tongue; pupils moderately dilated; patient with a tendency to sleep, but frequent awakening, crying with his head and always indicating the front, and often pulling his hair in his sleep. Conjunctiva injected, eyes red and somewhat swollen—photophobia; his face and body intensely dry, hyperemic and red, slighly albuminous urine simulating scarlet fever; never fully comatose, but was awakened with difficulty; after first week often complained of numbness of hands as well as of extreme coldness of feet and legs, although to the touch they seemed warm. About the close of the first week it was discovered that he could not articulate distinctly; he also at this time had some difficulty in swallowing. The red uncoated tongue persisted throughout, sometimes moist and sometimes dry. Obstinate constipation and frequent attacks of vomiting was kept up for four weeks. The pulse was variable —generally not increased. His temperature for four weeks varied from 100 to 101½. Skin of chest and abdomen was always dry and harsh to touch, exfoliating since recovery.

The duration of this case is hard to determine. At the end of fourth week he was without fever, but cried with headache for two weeks longer; and at the close of two months, although somewhat improved in flesh and appearance, he had a recurrence of

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most of the symptoms with a temperature of 101 for one day, since which time he has steadily improved, though at the present (April 20th) he has marked stiffness in both knees with slight inco-ordination.

CASE 8.—Lizzie W., age 9 years, granddaughter of Case 4, sister of Case 7.

History.—Sunday evening January 1st, had a chill followed by high fever, vomiting and intense headache. Saw her first Wednesday January 4th, temperature 102, pulse 120; intense headache "occipito frontal," she expressed it "my brains are coming out." Her neck was quite rigid and head somewhat retracted; tenderness over cervical spine; pupils dilated, slightly responding to light. Irritated conjunctiva, photophobia. She was so generally hyperesthetic for a week that she could not be removed from the bed. When she was raised to sitting posture she complained of extreme dizziness and frequently of double vision. About the close of the first week she experienced for several days great difficulty in swallowing. During second week she was absolutely unconscious for two days, when it was observed that she had convergent strabismus of left eye, and at this time Cheyne-Stokes respiration was also observed. Hearing impaired the third week. The only delirum observed in this case was "night terrors." The bowels, although requiring laxatives, were easily moved. Heart's action always rapid and alarming. The fever during the third and fourth week was intermittent and exacerbations being followed by sweating, sudamina developed on neck with large vesicles on back. Convalescent in five weeks.

CASE 9.—Baby W., age 15 months, grandson Case 4, brother Cases 7 and 8.

History.—Mother thinks it had a chill Sunday Jan. 1, 11 a.m. This chill was followed by vomiting, fever and intense redness of the skin, the redness lasting but a few hours. Fever and vomiting persistent. I saw him first Jan. 4th, temperature 103, pulse rapid photophobia, pupils dilated. So great was the hyperesthesia that child could not be moved except on a pillow and clothing was cut for removal. Marked rigidity of spine and retraction of head. Child cried out as if frightened when sleeping. Facial expression dull and indicating pain; vomiting occasionally. Temperature varying from 100 to 102 throughout; diarrhea persistent. This case, contrary to my prognosis, made a complete recovery in four weeks.

CASE 10.—Mr. L., age 29, son-in-law of Case 4 (reported to me

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by his wife). "Had lagrippe for two weeks with soreness of stomach but was much improved, and Sunday, Jan. 1, said he felt well and started in a buggy to make a drive of nine miles, although the day was cold. When about three miles from home he began to experience the sensation of his lungs filling with cold air, with difficulty of breathing. Immediately he felt as though he was freezing and stopped at a house to warm. In an hour or so he started to return feeling as though his 'muscles were tearing'. On his arrival home his face was covered with purple and white spots and a very high fever which continued during the night. Next morning he complained of headache. A few minutes later or about five o'clock, he vomited and fell back unconscious. He was unable te speak but so violent were his struggles that it required several men to hold him in bed. At times he would lie with eyes closed as though the light irritated them. His tongue was dry and red and breathing irregular (she, his wife, described it as Cheyne-Stokes) and at last blowing; I believe he knew me until a short time before death as he would watch me and once when I was crying, tears rolled down his cheek." He died at 1:30 a.m., Jan. 3rd, living about 49 hours after his chill. Dr. Gregg informs me that he catheterized him, tested his urine and found albumen.

I take from my reports the following case, reported by Dr. Gregg:

CASE 52.—"Male, age 7 months, highest temperature 102; usual 100 to 101. Cheyne-Stokes respiration observed at different times; cried out in sleep and when moved; cervical rigidity; stupor; two or three convulsions near close; bowels constipated; intense hyperemia of the skin. Strabismus after the second week. Ear sensitive to noise. The disease is of especial interest as it nursed its mother after she was affected with the same disease. Duration of illness, three weeks. Death."

The following by Dr. Colcord:

CASE 56.—"Female, aged, 22 years. Initial chill; highest temperature 104½; intermittent; pulse 144; irregular; Cheyne-Stokes respiration. Intense occipital headache; general hyperesthesia; rigidity and retraction slight; violent delirium; profound coma on second and fifth days; tongue, dirty coat; diarrhea with involuntary actions. Characteristics: petechia eyes, intolerant of light; joints tender and rigidity of fingers, wrists and knees; retention of urine; died in five days. Contrary to my directions her child was allowed to nurse, and in seven days after the

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mother died, the child became infected." (See Case 52.)

These 12 cases would indicate that this disease is contagious, where exposure was great enough and conditions favorable. The small bedroom in which cases 1, 2 and 3 slept, coupled with the unsanitary conditions as well as the close relation existing between child and mother. The crowded illy-ventilated room in which cases 4, 5, 6, 7, 8, 9 and 10 spent the night, and the nursing of mother by child as in cases 52, 56, would seem to supply all necessary conditions for contagion. The above cases seem not only to indicate contagion, but that the stage of incubation is from seven to ten days. This disease, however, must be mildly contagious, as all the other cases were single to a household, and in my own practice, no special attempt was made to isolate patients from the rest of the family, and exposures were numerous.

The initial chill was observed in 45 cases. Of those so affected, 30 cases died while 14 recovered, and one is still sick. When we consider the total number of deaths is 67 per cent. of total reported, and the deaths of those cases in which chills were observed is 66 per cent., we would decide that the chill has little prognostic value; but as the chill was observed but four times in children under 2 years of age, and 20 of that age have died, it would materially change the percentage.

Highest temperature, generally initial, noted in 70 cases.

	Cases.	*Died.*	*Recovered.*
Subnormal.....	3	2	1
Normal to 101.....	8	4	4
101 to 102.....	15	8	7
102 to 103.....	14	8	6
103 to 104.....	15	12	3
104 to 105.....	4	3	1
105 to 106.....	4	4	0
106 to 107.....	1	1	0
Noted as "high".....	6	6	0

It would seem by the above table that a high temperature would indicate an unfavorable prognosis.

The pulse has no special diagnostic nor prognostic value. My reports show that in eight cases it was below 60 beats per minute, four of these cases having a pulse of 40. Extreme rapidity was noted near the close of the fatal cases. Pulse does not conform to temperature wave.

Abnormal respiration was noted in 47 cases; Cheyne-Stokes

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respiration was observed in 33 cases; in 17 just before death, in 16 earlier in the disease, four of the latter recovering. This would seem to indicate a very grave symptom. I also found in very young children, much diagnostic value attached thereto. Three cases had irregular respiration, one dying and two recovered. Three cases had stertor, one dying and two recovering. Two had labored respiration, one dying and one recovering. Five cases reported as having shallow and rapid respiration, four dying and one recovering. One case with sighing respiration recovered.

All the cases that were able to speak complained of headache, generally intense and severe. They are described as occipito-frontal, temporo-occipital and occipital. Of the cases in which 22 had headache classed as "intense," 16 died.

General hyperesthesia was noted in 38 cases. Moderate spinal rigidity was noted in 28 cases. Of these, 15 recovered; while marked rigidity was noted in 38 cases and only five recovered—thus indicating a very grave symptom. Retraction of head corresponded with rigidity of spine in extent and results.

General convulsions were noted in 20 cases. (Character of same not stated except in very few cases.) Of these, 19 died. Local convulsions as of arm or leg, nine cases, generally tonic, and in several instances followed by paralysis of the convulsed parts, of which only three cases recovered. In two cases, paresis of right side and four of left side was observed, while two of the above cases had facial paresis. In one case it was opposite from leg and arm and the other on the same side.

Violent delirium was noted in 10 cases, three of which recovered. Wild delirium in 10 cases, and only two recovered.

Low muttering in two cases and both died, while mild in two cases, and both recovered. Delirium character not stated in eight cases, three recovered. Night terrors in 14 cases, seven recovered.

Some degree of coma was noted in 32 cases. Sixteen cases as profound, 14 dying and two recovered, one coma vigil is still alive though not convalescent, (now dead); of the 15 cases reported as having "stupor" and "mild coma," eight died and seven recovered.

Vertigo was a symptom in 14 cases. Patients either falling or complaining of dizziness; of these cases nine died and five recovered.

Vomiting was noted in 53 cases, nine as initial only; 42 cases as initial and frequent, and two cases as appearing the second day. Of these cases 37 died and 16 recovered.

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The condition of the tongue was noted in 56 cases, and is variously described as "coated;" 16 times, as "dirty-coated," 13 times, a "white-coat," 6 times, a "dirty-yellow or dirty-brown," 18 times, 3 cases had "red uncoated" tongues, while red edges and tips are mentioned 14 times. From these reports we are led to infer that in this disease we have no characteristic tongue.

The bowels as to action were noted in 60 cases; 42 were constipated, 9 had involuntary action (of these latter, 7 died and two recovered.) In three cases diarrhea and constipation alternated; four had diarrhea and involuntary action of bowels, while in but two cases, bowels were natural.

Twelve of the above cases were tympanic, and three had retracted abdominal bowels. (By an oversight in preparing report blanks these last two symptoms were not especially asked for.)

Of the skin symptoms, herpeslabialis was observed in 5 cases. Characteristic petechia was observed in 13 cases, all of which died.

Intense erythema, generally initial, was observed 9 times. Vesiculo-pustular blebs followed two cases. Large purplish spots in one case; rose-colored spots in one case; brown spots in two cases; sweating of the head alone 3 cases; and in one case, right side of the head only. Sudamina reported 4 times.

Symptoms of the eyes noted: photophobia was reported in 15 cases; dilated pupils in 24 cases; contracted pupils in 2 cases, while 2 cases were reported as variable, quickly changing from a state of contraction to dilatation and *vice versa*. Eighteen had strabismus, 16 convergent and 2 divergent. Only 1 of these cases recovered. Nystagmus was observed one time; ptosis 3 times and diplopia once. Argyle Robinson pupils 2 cases.

Hearing was notably impaired in 15 cases; 3 were hypersensitive to noise, and three had discharges from ear.

The urine was not generally examined; but albuminous urine was reported in 4 cases. Retention in 5 cases, and incontinence in 2 cases. Unfortunately, "Tache cerebrale" was not looked for in many cases. I observed it in 5 of my own cases, while in 3 other cases, comprising all that I examined, it was absent. Dr. Fisher observed it in all of his cases.

The total number of deaths were 49; of these, 27 were males, and 22 females. Total number of recoveries, 23; 16 males and 7 females, one male being still sick. Of those cases that died 4 are reported as dying within twelve hours; but as these cases were, with one exception, all small children, the initial chill was

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not noticed, and errors could have been easily made. The exception was a boy 11 years old, who died 12 hours from the initial chill.

12 died between 12 and 24 hours, 5 on the second day, 3 on the third day, 6 on the fourth day, 6 on the fifth day, 1 on the seventh day, 3 the second week, 7 the third week, 4 the fourth week, 1 the fifth week, 1 the sixth week, 1 the seventh week.

One case recovered on the third day, 1 in one week, 8 during the second week, 2 during the third week, 5 during the fourth week, 4 during the fifth week, 1 the sixth week, 1 the seventh week and 1 the eighth week. Not believing in the existence of the so-called "abortive form," I regard with suspicion the diagnosis when patient recovers in first week, and I have eliminated from my report 12 cases observed in my own practice where symptoms subsided inside of one week. This is also the expression of almost all the gentlemen who have assisted me.

As to age: Of those 1 year and under, 15 cases, 7 males and 8 females, all died; of those between 1 and 2 years of age, 8 cases, 7 males and 1 female, all died except 3 males, and 1 of these will probably die. Or those between 2 and 5 years of age, 10 cases, 8 males and 2 females, 1 male and 2 females died; of those between the age of 5 and 10 years, 9 cases, 3 males and 6 females, 1 male and 4 females died.

The above would indicate that all ages are susceptible but that the age of the greatest susceptibility is from 3 months to 5 years, as this period furnishes us 33 cases, while the next 5 years furnish but 9 cases.

Sequelæ, were observed in but 7 cases; one boy 4 months after attack, had some rigidity of both knees, slight inco-ordination. Another, a girl 3 months after, has joint pains—rheumatoid. One has paresis of left arm with ptosis of left eye. Two cases have strabismus; another, a female 20 years old, has choreic movement, one has torticolis, another slight inco-ordination of muscular movement.

The treatment was necessarily symptomatic and varied. All agreed on the use of opium for the relief of pain, and in several cases marked tolerance of this drug was noted. Dr. Blair reports a case, a 7-year-old boy, who was, in what he considered, as almost a dying condition: stertorous respiration, marked rigidity with extreme opisthotonous, to whom he administered hypodermically within an hour ½ grain morpha-sulph., and an adult tube of aseptic ergot. The boy recovered. Three cases reported

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were with two exceptions, confined to two townships of Crawford county. Almost entirely to the coal mining region, where the general sanitary conditions are not the best; and where most of the cases were the house sanitation was bad.

From the Pittsburg undertakers who do most of the work in this section, I learn that 60 cases died with meningitis and brain fever, 12 cases with lagrippe, (which was probably in these cases another name for meningitis), and (estimating) at least 18 buried elsewhere or cloaked under such names as "bronchitis" or "pneumonia" by incompetent physicians, I think a conservative estimate would be 90 deaths from this disease, or perhaps 140 or 150 cases.

Our per cent. of deaths (67½) large as compared with rates of other epidemics is doubtless explained by the elimination as above cited, of the so-called "abortive form."

Note.—"Since above was written, another of above cases died."

DISCUSSION.

Dr. Gill: I desire to ask the doctor what period of time his report covers.

Dr. Porter: December 16 was the first observation I made, and yesterday I learned of the death of a child whose case is referred to, so that it covers all the intervening time.

Dr. Gill: The reports from Crawford county to the State Board of Health for January, February and March give 25 deaths for the three months. This does not include December, and does not include April or any part of this month. I desire to say we ought to have more such carefully prepared reports as this, and we would then be able to get at the facts in a more satisfactory manner. This disease is fatal enough, with all the information we can get, and it is now regarded as a communicable disease. By what method, however, by what means the communication is brought about, is not settled. But when a disease becomes recognized as communicable then we have an intimation to separate others of the same family from the surroundings, whether it is communicated from one individual to another, or whether it is communicated from causes that surround the family or the patient. The disease is so terribly fatal, and thus far science has done so little in the way of remedy for the disease, or in ascertaining the pathological cause of the disease, that we are glad of any information. The most recent and valuable information comes from the state board of Massachusetts, in which a

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most careful examination has been made of many cases, and the whole subject pursued in a most admirable manner. Those who are most interested in this subject I think can obtain the pamphlet published by the State Board of Health of Massachusetts, which treats the subject very fairly, carefully and thoroughly. Those three counties, Labette, Cherokee, and Crawford, have had a very large mortality from cerebro-spinal meningitis the last three or four months, and we shall hope to get carefully prepared reports from those counties during the next few months. In our report we state that it was a disease especially attacking children, and confined pretty largely to the cool months of the year. I greatly regret that we have not more that we can give in the way of treatment, successful or palliative in a large measure, but we cannot.

Dr. Sexton: I wish to state that this paper of Dr. Porter's is one that reflects credit upon this Society, it is so comprehensive and full. It is just the sort of paper that we need on a subject of this kind. Eighteen years ago while practising in Missouri I went through an epidemic of this disease. In the practice of Dr. McAllister, Dr. Brunton, Dr. Sneed, Dr. Calhoun and myself there were thirty cases, all of which I saw except one. Eighteen died, sixty per cent. All of us who have had any experience of any account have seen such cases, and have made observations similar to those reported by Dr. Porter. But the report of this epidemic I speak of, in the spring of '81, has never been put on record that I know of. I cannot go into details more than this, except to say that one of the marked symptoms that characterized many of our cases was suppression of the urine, and dryness of the skin, as mentioned by Dr. Porter. For this we used a drug at that time new, jaboranda. Whenever I have had sporadic cases of meningitis, and have observed that dryness of the skin and scanty urine, I have resorted to this, or its alkaloid form, pilocarpine, for relief. It always seemed to me to have some value, and I believe good can be accomplished in these cases by the administration of remedies that promote the secretions of the kidneys.

Dr. Dannaker: I believe that very few of the bad cases of meningitis that recover escape some after effects, eye trouble, muscular trouble, paralysis, idiocy, imbecility, some of these frequently follow. I would be very glad to hear this paper thoroughly discussed by members who have had experience and are now in general practice. I regard this paper as very important, and Dr. Porter deserves great credit for treating it so well.

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Dr. Schenck: I suppose all things except the eternal have or had a beginning. In cerebrospinal meningitis there is always a first case. If in attending that first case we look after sundry matters we will probably prevent a second case. The environment of a case of cerebrospinal meningitis is perhaps as important as that of any other disease that we will be called upon to treat. The gravity of the disease, the fatality of the disease, demands that every physician who is called to attend such a case shall give its environment careful attention. It is a disease that is no respecter of persons. Neither age, sex, nor previous condition protect against it. While many cases occur in early life, the last case I had shows the wide range to which it extends, and that you hardly know where to expect it. I was sent for to see an old soldier in western Colorado, a large orchardist and ranchman. I thought it was too far to go, some miles over the mountain, the weather very cold and threatening. They said we will come after you with a covered carriage and take you out. Under those conditions I consented to go out, and I found the old soldier in a comfortable style and surroundings, all environments seemed to be good, except on looking around the house I found it ill-ventilated, and except that slops were in evidence in many places near the house. The old man was wildly delirious, and had every symptom of cerebrospinal meningitis. I had things cleaned up to some extent, and gave the whole family prophylactics. Heavy snow came on and I remained there some time in preference to riding to and fro, and there was speedy recovery with no new case developing. Now I think the care of the physician was entitled to some credit for not allowing new cases to develop. The physician's first duty is to prevent the occurrence of another case, whilst he is curing the case he is called to attend. We do not recognize as a profession, as thoroughly as we should, our relations to society and our duties as sanitarians, our duty in preventing the development of further disease of any character whatever. It may be that we are called upon to treat. I think that in the beginning almost any of these epidemics may be arrested, and any case may be prevented from becoming epidemic. But if there is neglect in the beginning, you may have an epidemic that it is difficult to stamp out, and many of your friends will drop out, and you will gain little credit for the profession in the cure of your cases.

Dr. Goddard: My experience agrees with that of Dr. Sexton, in relation to the efficacy of pilocarpine. I treated a case in

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February or March, a little girl about five years old, in which I relied almost entirely upon opium in the first part of the treatment. The child was deaf in one ear, there was rigid retraction of the cervical muscle, pains in the head. She had recurrent attacks and I was very much tempted to give quinine, but was very glad I did not. I put her on iodide of potassium and jaboranda, and a week afterward she was completely well. I had given iodide of potassium before without result, but when combined with jaboranda it seemed to work like a charm.

Dr. Latta: There is beginning to dawn upon all of us the idea that the cell structures of the body are the definite element we must deal with in disease. All activity, either of health or disease, has its source in cell activity, and if we are going to reach disease it is very evident that we must search further among those little microscopic structures, the cells. Within the last few years, as most of us know, there has been separated from the nuclei of cell structures a distinct element called nuclein. The theory of it is that in nuclein you have the substance which being supplied enables the body to resist the approach of disease. This is a theory which has been pretty thoroughly tested. I have myself used it in tuberculosis, and in typhoid fever. It has been used by others in diphtheria, scarlet fever and other diseases, and seems to have a fine outlook. Physicians disposed to try this remedy have a choice of several preparations, nuclein solution, protonuclein and others.

Dr. Slaughter: I have recently attended a child about eighteen months old, undoubtedly a case of cerebrospinal meningitis, exhibiting all the characteristics described by Dr. Porter in his paper. The child had been sick about ten days and seemed when I last saw it on the fair way to recovery although not fully recovered. The child had over 250 convulsions. There have been no other cases reported in that community, although the disease is spread over considerable territory. It is quite possible this child will die yet.

Dr. Akers: One week ago I was called to see a young lady aged eighteen years, with a completely developed case of cerebrospinal meningitis. Dr. Lewis of this city was called into consultation, and confirmed the diagnosis. I have had some success in the use of the antipneumococcic serum.

Dr. Tiffany: I want to ask Dr. Porter if he has made any post mortems.

Dr. Porter: I have in a number of cases.

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Dr. Tiffany: I would recommend, with some confidence, pilocarpine, followed by nuclein.

Dr. Campbell: I have had six cases in Olathe during the spring, the first in February, which was reported by Dr. Gill as congestion of the brain, but I am now quite certain it was cerebrospinal meningitis. The ages ranged from seven years to sixty, and all died. The first case that died was a child seven months old. From what the parents said it had been sick only two hours. It did not die in convulsions, but was perfectly spotted; I never saw a case that could more truly be called spotted fever than that. All died within twenty-four hours in spite of everything. Some were apparently in good sanitary surroundings, but this was not true of the child, where the surroundings were not at all favorable. In other cases they were better, but I did not see much difference. The cases were separated over a distance of several blocks. In regard to public funerals, we had quite a little to do. The board of health prohibited a public funeral in one case, which gave rise to some contention. But the board stood firm and insisted on their prohibition, and it was carried out. I would like to hear further expression in relation to contagion and infection, and if it is to be so regarded public funerals ought to be stopped.

Dr. Carson: I wish to inquire if any of the members have tried bichloride of mercury hypodermically. I saw a report of its use, one centigram along the spinal cord, and it was said to have saved many cases. I have had two cases, one now convalescing and one died. I think the environment has more to do with it than anything else. My belief is that the disease is not at all contagious, but is due to surroundings. If you will go in the country where I have practiced, and see the surroundings and the source of water supply in these cases, you will be very quickly convinced of this. Both of these cases used water from wells in ravines, localities where water stands. One of the wells is in a corral where cattle and hogs run indiscriminately. If you should say that water was adapted for human use, I would differ emphatically.

Dr. Gant: I think this is the most important subject that could be brought up at this time in this Society, much more important than intricate surgical cases, or anything of that character. We are having an epidemic in Wyandotte county and Kansas City, and three or four out of five die. I think the treatment is the more important thing to go into. I think it is very difficult to get the skin to act. When that don't act, it is difficult to get

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action in other organs. I believe this is a disease that calls for vigorous remedies. If you give calomel give it in considerable doses. Action must be obtained as rapidly as posssble. It is useless to administer remedies that may take days to act, it may be too late in an hour, the patient may die before operation is secured. If you give bromide, give large doses, forty grains to a dram at a dose. Hydrate of chloral may be used. Whatever remedy you use push it for all it is worth, graduating the dose, however, of course, in accordance with the case. The average practitioner, when he gets into the body in making an autopsy is unable to preceive clearly what it is he sees. I have noticed in some cases physiciaus would say, "Why there is pus," when I did not see it at all, simply inflammatory lymph or serum. In depressions of the brain we find a lot of material, the exudate, like solidified glue or gelatine. The epidemic commenced with us about eighteen months ago. The serum has been spoken of, and I have seen good results from its use, and I believe it will do some good, but immediate effect is not to be expected. I think it is impossible that any benefit should appear within twenty-four to forty-eight hours. Our knowledge of the use of serum is very limited, probably few among us have seen it used to any extent at all. Iodide of potassium is of service, but not immediately. Probably not inside of three or four days. I do not think much advantage is to be expected from the nucleins, although they may modify the disease somewhat. I have used them to some extent, but think they sometimes produced little effect. Later experience may modify this view. I believe that every case that dies inside of twenty-four to forty-eight hours dies from pressure. The thing is to relieve that pressure as soon as possible by sweating and purging, and if that cannot be done tap the lumbar region.

Dr. Davis: I noticed in following the analysis of these several cases repeated reference to retention of urine, incontinence of urine or suppression of urine, and for relief in these cases jaboranda and pilocarpine have been recommended. There may be quite an advantage in the use of large doses of some remedies that have been mentioned, but I regard pilocarpine as a dangerous drug. It would be best in my opinion to begin with a small dose first, of pilocarpine, and if it is found to agree well with the patient the dose may be increased. Strychnia may be of use to counteract the pilocarpine to some extent. It is evident in some cases that the urea is not eliminated, suppression of the urine showing that the kidneys are inactive. So far as I am

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able to recall now Dr. Porter did not mention that in connection with any of the cases referred to in his paper there was a complete and thorough analysis of the urine for the determination of the amount of urea present. We may have albuminuria preceding the development of the disease, which is likely to result from inflammatory conditions. In any event I would advise extreme caution in the use of pilocarpine. I do not see the benefit or use of bichloride of mercury hypodermically. The reason for its use is not given. I should be inclined to think that large doses of iodide of potassium would aggravate the case. You get only the diuretic effect, which can be obtained by the use of simple diuretics.

Dr. May: About nine years ago I passed through an epidemic of cerebrospinal meningitis of one hundred cases, in which ninety died. Among certain classes of people there was of course a good deal of nursing. I do not regard the disease as in the least contagious, and do not think there is any objection to public funerals. There have been about twenty cases recently in my locality, of which I have seen six or eight. I have noticed two types of the disease, the one affected severely from the start, with coma at a very early stage. I have given stimulants, principally strychnia. When the delirious form has appeared have given morphia. I think in delirium morphia is the only remedy. I have used pilocarpine, but am afraid of its depressing effect in coma. I have tried almost everything. In the last five or six cases have used unguentum crede, rubbing it on the back of the neck. Two or three cases recovered, one died. I am quite well convinced that the disease is not contagious.

Dr. Minney: In 1873 I passed through an epidemic of cerebrospinal meningitis, in which about four out of five cases died. From what limited experience I have had I do not believe the location affects the disease, but unfavorable surroundings affect it. I consider it a germ disease, and I believe that public funerals should be prohibited.

Dr. Porter (closing): I am especially thankful to the Society for allowing me, without raising an objectton, to read so long a paper. I actually had a paper, before I knew it, that would have required an hour to read. Of course I could not discuss the pathology nor the etiology of this disease, and I said very little on the treatment. In regard to its contagious character, I carefully reported the cases and the report shows my position. I see that the inspector of the health board of Chicago has re-

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cently written a series of papers for the *Journal of the American Medical Association*, and he classes cerebrospinal meningitis with consumption as mildly contagious. I believe it would be good to prohibit public funerals, and if it is dangerous to go to funerals it is dangerous to go into the house. Some of the later writers speak of loss of memory. I have tested some of the cases in regard to what has taken place during the illness, and have found no loss of memory. Scientific cleanliness is all right, and care for sanitary conditions, of course. But it is too late to lock the stable after the horse is stolen. I told the people of neighboring families to keep their children away, but children of families in which cases occurred could not be controlled. The cases were almost entirely confined to the poorest, as indicated in the paper. Families down there sometimes live in one room, very many in two rooms, and the wealthy among them sometimes have as many as three rooms. In regard to treatment, I want to tell you the use of opium in some form is absolutely unavoidable. Almost every case that has recovered has recovered under the use of opium, and in considerable doses. From my experience I think it is just as well to throw the bromides out. I have used them in large doses, as they are recommended in the old treatises, but I could not get the effect. I am afraid of chloral in cases of coma. In regard to ergot, which has been suggested, I have used it but just because the books tell me to. I do not know of the use of the antipneumococcic serum. It is adapted to a different germ from that of this disease.

Dr. J. E. Minney, Topeka Kansas, read a paper on "Iritis."

Iritis is an inflammation of the iris. It is one of the most fatal diseases to sight when it is let run its course. It is one of the most amenable diseases to treatment when seen early. The great danger is in not recognizing the affection early, and for this reason many eyes are lost from iritis that could be saved.

The iris is the front part of the second coat or tunic of the eyeball, being continuous with the choroid through the ciliary body, the three composing the uveal tract—it being called uvea from its appearance in color to the ripe grape.

The location of the iris, its anatomical structure, and its intimate relation to the other parts of the eye, makes it a dangerous organ when diseased.

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Its principal function is to regulate the amount of light entering the eye.

It is situated within a closed cavity and is well protected from external injury, but owing to its nerve and blood supply it is liable to disease from adjacent structures, from continuity of tissue and from systemic affections. Normally the iris is in constant contact with the lens.

The iris is composed of muscular and connective tissue, bloodvessels, lymphatics, nerves of every variety, ganglia, endothelium and pigment. It is especially rich in its nerve and blood supply. The whole structure is delicate and sensitive and the walls of its vessels thin, hence it follows that an irritation causing an engorgement of the bloodvessels and lymphatics of the iris is liable to permit an exudation and a gluing together or an adhesion of the iris to the lens—a posterior synechia, partial or complete. The attachments usually form at the inner ring or margin of the pupil. Here the bloodvessels are more numerous. If complete—a seclusion—an interchange of fluids is prevented from the anterior and posterior chambers. The tension of the eye may become more or less interfered with, or the constant nagging of the iris in attempting to contract and dilate in unison with the well eye, (if but one eye is involved,) will set up or keep up an irritation of the sick iris and cause a pathological condition of the ciliary body and choroid, through continuity of tissue, resulting in pthisis bulbi or disease in the good eye and total blindness of both eyes may result, or this exudate from the iris organize in the pupil and cause blindness by occlusion. One attack of iritis predisposes to another, especially if not treated early. If the cause of the iritis is a constitutional one, there is danger of both eyes becoming involved.

The form of iritis derives its name from the character of the exudation, viz: Serous, plastic, suppurative or hemorrhagic.

Cause of Iritis.—The causes of iritis may be local or constitutional. By local we mean from trauma, or the iris becoming involved from adjacent structures. The constitutional diseases affecting the iris are such as syphilis, rheumatism, gonorrhea, malaria and tuberculosis. The constitutional disease causing iritis most frequently is syphilis. This is due, probably, to its involvement of the blood vessels. When a case presents itself, unless traumatic, suspect syphilis, and if it proves to be a mistaken diagnosis, it will be a safe one. Iritis and glaucoma are two of the most fatal diseases of the eye to sight when not early diagnosed, and

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the physician who has not lost one or more eyes from one or both of these eye affections has been fortunate in his practice or is a good oculist.

Diagnosis.—Iritis is recognized by some or most of the following symptoms: Dread of light, pain in the eye, sometimes radiating in the brow and temple and a sensation of a foreign body in the eye, contraction of the pupil, a change in the color of the iris with a rough looking appearance and a loss of its tracery, a red rosy ring around the iris commonly called "pericorneal injection," a cloudy aqueous, the pupil responds slowly if at all to light and shade and dilates sluggishly or irregularly or not at all under atropia. The sight of the eye is frequently impaired early, especially when the aqueous is cloudy. Pressure on the eyeball causes pain.

A careful inspection must be made of the offending eye to see if there is a foreign body on the cornea. The eyelids must be everted and the whole conjunctiva examined to see if there is a foreign body present or disease of the adnexa. The sight of the eye may be tested and a comparison made always with the well eye, noting its color and general appearance. It must be remembered that the irides may possibly differ in color in the same individual. A blue or gray eye becomes green, a black eye a dirty brown. In syphilis pink or yellowish colored nodules may be seen on the front part of the iris near the pupil. If there is a suspicion of iritis give the patient the benefit of the doubt and use atropia. It will clear up the diagnosis and if iritis is present the first and most important local treatment will have been given. To shorten a long story, I believe that in iritis of systemic origin and sometimes of local origin it is as necessary to make a careful physical examination of the patient in general as in a case of typhoid fever, pneumonia or diabetes, or any general bodily affliction.

Prognosis.—The prognosis in a case of iritis is good if seen early and bad when seen late in the disease. By late is meant when adhesions have formed which cannot be broken up. Adhesions of the iris to the lens (posterior synechia) will take place in a few hours but can usually be broken up within a few days after the attack. I have seen cases of months and years standing greatly benefited by treatment when caused by syphilis. Local treatment must be given in these cases but the main reliance is constitutional medication. When pathological changes have taken place in the iris tissue as shown by a change of its color and

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adhesions that cannot be broken up and there are frequent outbreaks of inflammation in that eye, although it quiets down for a season, the prognosis is particularly unfavorable and phthisis bulbi is likely to set in and there is also greater danger to the fellow eye and of total blindness to both eyes.

The disease lasts from a few days to many weeks.

Treatment.—The treatment consists in relieving the pain, protecting the eye and removing the cause of the disease.

The pain is relieved by the use of atropia, heat or possibly cold, blood-letting and internal medication.

Atropia is the local sheet anchor. It dilates the pupil and thus prevents attachment of the iris to the lens by stopping the seaping of the fluids through the vessels; it relieves the pain by squeezing the blood out of the distended bloodvessels, it sooths the terminal nerve filament of the iris by its anodyne effect, possibly; it paralyzes the muscle of accommodation, the ciliary, putting to rest the whole mechiansm, and it breaks up adhesion, already formed if not too strong, and it clears up the diagnosis.

Protection to the eye is afforded by dark smoked glasses, (preferably plain ground,) or a dark shade. Heavy pads or bandages which retain the secretions in the eye and retain the animal heat are positively injurious and should be prohibited, especially is this true if the cornea or eyelids are also involved. This protection is a means of relieving pain.

If the iritis is caused from eyestrain rest from eye work, and properly fitting glasses to correct the error of refraction must be given when the eye gets well. If caused secondarily, that is from keratitis, granulated lids or disease of other adjacent structures those diseases must be treated, but the atropia continued. If due to constitutional trouble, such as syphilis, appropriate internal medication must be given. If the pain is not relieved hot or cold applications may be used, some of the coal tar preparations or an occasional dose of morphine and atropia, at times leeching the temple with the natural or artificial leech, and freeing the bowels with a good dose of sulphate of magnesia, will act like a charm in relieving the pain and hastening a cure.

A patient with acute iritis is a sick patient, out-door exercise should be taken but all physical labor, (this includes eye work,) should be prohibited. It may be necessary at times to keep a patient in a dark room, but it is unfortunate for the patient. A dark room is generally poorly ventilated aside from the depressing influence of continual darkness on the patient. Cold appli-

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cations are indicated in traumatic iritis for the first twenty-four to thirty-six hours.

I am aware that I have said nothing new in this short report. My sole object has been to emphasize the necessity of the utmost care in the examination of a sore eye that the character of the disease may be certainly known. If all of us would do this I feel sure many eyes would be saved that are now lost from *iritis*.

DISCUSSION.

Dr. May: The importance of making a proper diagnosis and applying the proper treatment in the case of eye tronbles is clearly manifest. There are no doubt cases presented to the general practitioner that he is too apt to turn off lightly, and to administer something that may be harmful, or, if harmless, may serve to defer proper treatment until the difficulty has become more serious. The thing of consequence is to make a careful diagnosis as between iritis and glaucoma, which are similar in appearance to a certain extent. In glaucoma, however, the pupil is dilated, while in iritis it is contracted, and if you apply the wrong remedy, the remedy for glaucoma in a case of iritis, it is not by any means harmless Atropia is a very serious thing to put in a glaucomatous eye, and it is the thing to put into the eye in iritis. Constitutional treatment is very important in syphilitic and malarial cases.

Dr. Minney: A book could be written on iritis, and I had put the chips on my shoulder, and I knew if some of you oculists were here I should have them knocked off, and I was hoping some would be here. The importance of this subject has been forced upon my notice. I will say that I have seen more eyes totally and irretrievably lost from iritis than from any other disease, and principally because it was unrecognized in the beginning. In many of these cases my impression is that the physician hesitated in using atropia. But I say to you that if I was in any doubt whatever, I would dilate the pupil, and I would soon know what I had to deal with and would follow it up. Another idea, that a man who is treating specialties need give little attention to general medicine. I imagine that the man who is well up in general medicine, and knows little in comparison of his speciality is far the more competent. The importance of early recognition of iritis is clear enough when it is borne in mind that a mistake may be followed not by the loss an eye only, but by total blindness.

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Dr. Spencer Pitts, St. Joseph, Mo., read a paper on "The Development of the Teeth."

Mr. President, Ladies and Gentlemen: I am here by the invitation of your committee to consider the subject of the development of the teeth.

Being a dental surgeon I would naturally be expected to consider the subject from that standpoint, but it is my desire to so present it to this body of general surgeons that they may clearly appreciate the mutual interest we all, general and special surgeons, have in it.

The American dental surgeon in daily contact with the problems of his calling, stands appalled at the conditions confronting him. The ravages of disease breaking down the organs of mastication seemingly faster than his efforts can build them up, until sometimes it seems inevitable that after a while we must become an edentulous people. We are called upon to treat pathological conditions, and our efforts can only be remedial. But we appeal to you to take this matter from a physiological ground, and in your care of mother and babe, so strengthen the coming generations that the necessity for our services shall lessen rather than so enormously increase.

Tooth-development is perhaps the most difficult subject that embryologists are called upon to demonstrate. The study of the development of hair and glands is comparatively simple,—of calcified products alone do not deem intricate; but when we approach the consideration of both these conditions in one structure we appear to have met a mystery indeed. It is only as we approach the problem from the standpont of general histology, that we reach a clear and true interpretation of the phenomena of tooth development.

A microscopic examination of the intimate tissue concerned in tooth development led to the discovery that the teeth are developed in the mucous membrane, that instead of standing in close relation to the bony skeleton of the body they are a part of its outer or dermal system; that they are developed in a similar manner to the hair, nails and glands, by a process of involution, besides conducting us to new truths concerning the nature and constitution of the teeth. The microscope has shown us how to apply this knowledge in a better system of hygienic rules which aim at rendering their decay less rapid, their life more vigorous, and their loss less frequent.

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In the human foetus at the fourth week, in the epiblastic layer which covers the gums is seen the first indication of that cellular activity which later will result in the evolution of the teeth. The thickening of the epithelial covering of the gums is at first general, and results in the formation of a thick layer termed the dental ridge and underfits the band; from this band at regular intervals are given off small buds which soon extend into slender cords, each cord developing in time into the enamel organ of a tooth temporary and permanent.

The papilla which will constitute the future pulp of the tooth is developed from subepithelial connective tissue of the jaw. Its growth is upward or gumward, while the growth of the cord or enamel organ is downward into the substance of the jaw, the combination of these two elements into one organ seems to fulfil the same office as does fructification in the egg—process of invagination setting in by which the two tunics are formed, the enamel organ appears to be the matrix former; as the fetal femur is to the mature femur so is the enamel organ to the fully developed tooth, and the intimate connection between the surfaces of the enamel organ and the nerve organ is only that of perfect adaptation.

Vessels or nerves have never been demonstrated to pass from one to the other. The relation is analogous to that sustained by the epithelium and dermal layers of the mucous membrane of the oral cavity from which they have there origin. Springing from the base of the papilla are seen two processes which are connected with the papilla. These are sections of a circular process which arises all around the base of the papilla, and extending up and around the outer part of the enamel organ envelops it as an outer tunic, and eventually forms the pericementum, and as such becomes the cement organ, and these three organs, the enamel organ, the nerve organ and the cement organ, are the only structures which superintend the calcification of the tooth. In the microscopical examination of dense animal tissues, or such tissues as are impregnated with the salts of lime, it becomes evident that they, like vegetable structures, have periods of growth and rest, which are illustrated by concentric layers or zonal shades, and that, while these conditions are normal, they are both modified and intensified by the genius presiding over the function of nutrition.

But it is to be regretted that in dating the progressive solidification of tissues, we can with a degree of certainty mark the be-

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ginning and the end only, the intermeditate lines merely approximating the condition which we attempt to illustrate; yet they are near enough to exactness to give a comprehensive idea of the condition of the average tooth at a certain age, and in so doing they serve as an important guide in the performance of many necessary operations. By the seventh week of intrauterine life and when the embryo is less than one and a quarter inches in length, preparation is made for the development of the enamel germ or matrix, followed in the ninth week by the dentine germ, these germs continuing in or through their grogressive stages until the seventeenth week, when we find in the incisors and cuspids the border line between the enamel and dentine germs receiving depositions of the salts of lime. By the end of the nineteenth week the same developmental process has reached the molars and from this period until the fortieth week, or time of birth, the growth of the tooth germs and their calcification progress simultaneously. At birth the calcification of the crowns of the eight incisors is quite complete; the four cuspids and four first molars are fully two-thirds calcified, and the four temporary second molars have their crowns for half their length, solidified by the same process. At the end of the following three months, the infant enters into the critical period of its life, and from a glance at the condition of the twenty deciduous teeth and their progressive developmental changes it is fair to assume that this condition has not a little to do with the various abnormal systemic lesions or disturbances to which the child is liable at this age.

In close proximity to the sharp and irregular edges of the calcifying extremity of each partial or complete tooth crown lies the vascular papilla-primitive tooth pulp and any want of correspondence between the absorption of the overlying gum at the coronal extremity and the deposition of solid matter at the calcifying or papillary extremity must produce, by this retarding influence, an irritation limited in its extent by the number of teeth advancing, the duration of the cause and the ramifications of the trifacial or fifth pair of nerves, and the extent of the sympathic disturbances to which they are liable. The necessity for operation when the irritation becomes pathological is unmistakable, and the great advantage to be gained from the free use of the lance must be apparent.

When we consider the time of calcification it is not a matter of surprise that the crowns of deciduous teeth are much less fre-

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quently subject to malformation and defects arising from the deficiency in the quantity and quality of enamel and dentine than those of the permanent set. The crowns of these teeth are largely provided for in embryonic life, and unless the mother during gestation is in markedly poor health, so that the function of nutrition is but imperfectly performed, the foetus invariably escapes the necessary consequences of imperfect nutrition, which is so common after birth; yet if during this important period to the embryo there should be a prolonged attack of ill health and systemic depression, the crowns of the deciduous teeth would give its history by deficiency in the quantity and quality of enamel and dentine.

At the fifteenth week of embryonic life preparation is made for the development of the four first permanent molars, and following close upon these, in the sixteenth week, is the inflection giving rise to the enamel organ for the twenty anterior permanent—the successors to the twenty deciduous—teeth, and from this period until the birth of the infant the germs for twenty-four of the permanent teeth are passing through their several progressive stages preparatory to receiving the salts of lime. At birth then, the child has not only the twenty deciduous teeth largely advanced toward calcification, but has germs of twenty-four permanent teeth, in twelve of which calcification commences the first year. The germ of the second permanent molar appears at the third month and that of the third molar the third year after birth.

The permanent teeth, unlike the deciduous, are during the periods of calcification constantly subjected to the influence of morbid systemic conditions, and any abnormal nutritional condition, of but a few days duration, if occuring during the period of coronal calcification, is sure to make an impression upon the crowns of the teeth, which are at the time undergoing this process. Markings or defects being located at the point of calcification and limited in extent or modified by the severity and duration of the abnormality or lesion. If serious nutritional disturbances have occured prior to the termination of the tenth year some one or more of the permanent teeth must in all probability have recorded it.

Before the end of the first year the four first permanent molars and the eight incisors have all received a portion of their lime salts and before the termination of the third year twenty-four of the thirty-two teeth are in this process of development. The fifth

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year the second permanent molars and the eighth year the third molars or wisdom teeth commence calcification.

With the permanent set it is rarely that the patient suffers from the effects of interrupted dentition, as is so frequently prominent in first dentition, yet at times both the cuspids and bicuspids are so retarded in their eruption by the persistence of their deciduous predecessors, or by a small and contracted condition of the maxillary bones that serious trouble results; also from induration of the gums or non-absorption of the anterior portion of the ramus or tuberosity either the first, second, or third molar may be the cause of much local inflammation and a febrile systemic condition, and especially in this invariably the result of an impacted third molar.

The decalcification or absorption of the roots of the deciduous teeth commence in the incisors before the close of the fourth year, progresses gradually when normally accomplished, from the extreme end of the root toward the crown for about three years, and usually releases this deciduous crown between the seventh and eighth years, the central incisor being some months in advance of the lateral. The absorption of the roots of the first deciduous molars occurs a year later than that of the lateral incisors, commencing about the middle or close of the sixth year and terminating with the removal of the first diciduous molars, about the tenth year the second molars following usually some months or a year later. The cuspids always the last of the deciduous teeth to be shed have their periods of absorption from the eighth to twelfth year.

This absorptive process is purely a physiological action though somewhat obscure and might be termed the dissolution of the deciduous teeth. What induces this molecular dissolution is hard to determine. Though the several conditions which are always present are readily recognized, yet the part they play is so obscure that it is not readily ascertained. The manner of its commencement where successful is always at the end of the root, and require the presence of a vascular papilla in close proximity to the absorbing surface together with pulp vitality. These are three essential accompaniments, and the absence of any one of them would militate against the completion of the process. That the organs having thus served their purpose, and that the nourishment which had previously been appropriated by them is diverted or relegated to their successors, is probably the most plausible explanation that can be given of this interesting physiological process of temporary tooth absorption on the one hand and of permanent tooth generation on the other.

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Dr. G. A. Boyd, Edgerton, Kansas, read a paper on "The Year's Progress in the Study of Malaria."

The most important development of the past year concerning my subject, is the universal interest it has caused throughout the civilized world. The efforts of the race to protect itself against the natural resistance of the external world are largely determined by the nature of the obstruction. National history has so shaped its course, that America, England, France, Germany, Russia and Italy find their imperial ambitions opposed more by the resistance of tropical diseases than by international diplomacy. Chief among these is the disease caused by the hæmatozoon, plasmodium malaræ. England, Germany, Belgium and Italy have appropiated money for the scientific study of malaria. The British Colonial Secretary and the Royal Society have jointly appointed a commission of three: Drs. Stevens, Daniel, and Christopher, to study tropical diseases in British Central Africa and in India, where Surgeon Major Roland Ross is still at work on the relation of the mosquito to malaria. Germany has commissioned Dr. Koch for similar research in Africa. At the Edinburg meeting of the British Medical Association, one entire session was devoted to the reports and discussion of tropical diseases. Both in England and the United States schools for the study of tropical diseases have been organized. Mr. Joseph Chamberlain, British Colonial Secretary, and the Royal Society have established the London School of Tropical Medicine. The school is an extension of the Seaman's Hospital Society, and is located near Albert Docks as an extension of the hospital. It will be equipped with all the necessary laboratory facilities. In our own country, Dr. William Osler, of Johns Hopkins University, is at the head of the School for the Study of Tropical Diseases. So far our government has shown no interest in the investigation of malaria at home or in its colonies. Much work has been done, however, by the army medical officers. Italy has done more scientific investigation than any other country, and, it is well, for the disease holds five million acres much needed by its over-crowded population, infects two millions and kills fifteen thousand of her citizens annually. There is an Italian society for the study of malaria, and Professor Celli read its first annual report in 1898.

The two problems upon which this society centers its investigation, are: the existence of the parasite outside of the human

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body, and its means of entering it. On these two problems most of the work done has been by a few men in each country, since few are endowed with the extended grasp of phenomena, patience, exact observation, and intellectual integrity to record observations free from preformed judgments. To summarize the work done on these two problems: You perhaps remember that McCallum last year had demonstrated that in the halteridium of birds, the flagellate bodies impregnated the ovoid forms, corresponding to crescents in man, causing them to sporulate, and that in human malaria flagella entered the crescents but that they had not been seen sporulating afterwards. Patrick Manson, of England, had demonstrated that the filiaria hominis was taken from the blood of man, into the stomach of the mosquito, and there passed a phaze of its existance and was again introduced into the blood of man through the bite of the mosquito. Then Dr. Manson investigated the mosquito as an intermediate host of the parasite and found it in the stomach of the mosquito. Surgeon Major Roland Ross of the Indian medical service took up the investigation at this point. He saw the formation of the flagellate body in the stomach of the mosquito. Ross selected birds infected with an intracorpuscular parasite, proteosoma, and by careful experimenting traced the proteosoma from the bird's blood into the mosquito's stomach through the walls of which it passed into the body cavity where it lost its pigment enlarged in size (coccidia) became granular and burst, freeing a number of vermicules. He next discovered these vermicules in the venemo-salivary glands of the mosquito. He had already established that it was only in the gray mosquitoes that these pigmented bodies occurred. He now fed uninfected mosquitoes on infected birds, and in a few days fed these same mosquitoes on uninfected birds and found that the mosquitoes infected the birds. Dr. Ross telegraphed the British Medical Association through Dr. Manson his results at its meeting in Edinburgh, in July 1898. The importance of the successful termination of these scientific researches ranks it as one of the great achievments of the Nineteenth Century. Certainly the most complicated since Pasteur demonstrating the cause of fermentation and putrefaction at once laying the foundation for bacterial biology. The idea of attenuated virus and immunity conferred thereby is also a thought evolved by Pasteur. Now comes the Italian investigators and shut off the mosquito's last hope of escape. Celli demonstrated that a non-infected man when exposed to the bites of certain varieties of mosquito did

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develop malaria. Bastianelli demonstrated that the crescents of human malaria developed in the body of certain varieties of the mosquito. (Anapheles Claviger culex pencilarius and culex malaria.) Ross' experiments confirmed these investigations.

Grassi, Bastianelli and Bignami also found that the flagellæ formed from the chromatin substance of the crescentic and large bodies of tertain variety. The flagellæ may be observed developing in the chromatin elements and passing to the periphery where they escape and become active. Celli and Santori have found that the injection of serum from animals entirely immune to all forms of malaria prolongs the incubation period of malaria very much, but the serum of patients recovering from malaria has no immunizing power either for the patient himself or for those uninfected. Long treatment with quinine does not produce immunity but there is in some a congenital immunity, and chronic malaria has some effect on producing immunity. It is thought that the study of the cause of congenital immunity will yield good results.

Another line of investigation which broadens the view of malaria is the study of analogous forms of the hematozoon in the blood of other animals Texas fever in cattle produced by the *pyrosoma bigeminus*, a protozoa whose life history resembles the aestivo-autumnal parasite. The pathology of Texas fever and malaria have many common points. The cattle tick is the intermediate host of the pyrosoma. In Italy what they call malaria of cattle is so far as I learn identical with Texas fever, though in Italy it has been proven that the mosquito is the one source of its dissemination, and Celli has succeeded in saving many cattle by protecting them from mosquito bites. In case of Texas fever, the native cattle enjoy immunity, not from infection but from its destructive multiplication, and it was very evident that the negro soldier was not so seriously affected by malaria as the white soldier. Gustav Langman found hemosporidia in thirty-eight out of eighty-three examinations of American snakes and frogs, and a California observer found an hematozoon in a salamander and Langman filiaria in bull frogs. Dr. E. Van Tunzelman in the reports of the imperial maritime customs says he has found an intra-corpuscular parasite that quinine will not kill but which methylene blue will.

In this couutry our energies have been spent in studying the tropical malaria as introduced by the soldiers in the Cuban campaign. Dr. Coronado, of Havana, has reported that he has found

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the plasmodium in the excreta and vomit of infected patients where there was no hemorrhage of intestinal mucous membrane. He reports finding the parasite in water containing vegetal matter, also of cultivating it in well diluted sterilized broths. He has noted an amber hued aspergillus growing with it. He reports infection of sailors on a coast vessel. One instance is cited where four families had lived on a sugar plantation twenty years without infection, but when many infected persons sought refuge there during the reconcentration regime these families became infected.

The following paper, by Dr. William S. Gottheil, New York, on "Syphilis in the Family and the Community," was read by title.

It is not my purpose in this present paper to attempt to cover the extensive field that its title might be held to imply. It is rather to consider certain points in connection with the luetic infection which are of general interest, and certain sociological aspects of the disease, if I may call them so, regarding which general medical opinion is not yet clarified and fixed. And, whilst by no means disregarding the expressed opinions of authorities upon these various points, I shall base my remarks more especially upon a not inconsiderable clinical experience of my own, and give you, so far as I can, the definite conclusions that I have come to.

The subjects that I shall consider are such as necessarily appeal to the practitioner; for on them depends his attitude to the luetic disease both as a medical man and as a member of the community. Regarding some of them our patients themselves demand definite ideas and categorical answers. Yet some of them are treated of quite cursorily and insufficiently in our text books, and I am convinced that general professional opinion upon them is uncertain and indefinite.

Theoretical considerations and laboratory experiments have but little weight in determining the answers to the point herein to be considered. The positions that we ought to take as regards them is one that is impracticable. In the language of a distinguished American statesman, conditions, not theories, confront us. The answers of science to the questions raised are often such as we ought not to give.

So much as preface and a statement of the point of view from which I propose to consider these subjects.

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The subjects that I propose to consider briefly are the following:

1. How early in the syphilitic disease is it possible to make a positive and definite diagnosis? Can it be done from the chancre alone?

2. Can syphilis be cured at all?

3. What is the best practical method of treatment?

4. How long must treatment be continued?

5. What should be the attitude of the physician as regards the family and social surroundings of the syphilitic?

6. At what period, if at all, can an individual infected with syphilis be considered cured, and when can he be permitted to assume all the family and social relationships of the non-infected individual?

1. Since syphilis is occasionally a dangerous and always an eminently contagious disease, it is manifestly important, both for the patient and his surroundings, that the diagnosis should be made at the earliest possible moment. And since in almost every case there is a preliminary period during which the chancre, the local initial lesion, is the only sign of the infection, the question narrows itself down to this other one: Can the diagnosis of syphilis be made from the chancre alone?

Medical science answers no to this question: but medical practice must answer yes. Most cases of typical initial lesion are followed by constitutional syphilis, but not all of them. I have on record a number of carefully observed cases in which a lesion presenting all the clinical features of the infecting sore have not been followed by the disease; some years ago I recorded some of them in a paper entitled "Pseudo-chancre," (*New York Medical Journal*, September 28, 1895,) in which a gumma or an irritated chancrodial lesion simulated the chancre in all essential points. These exceptions have caused many authorities to answer no to the question propounded.

But our patients demand a different reply. They come to us trembling with anxiety, fearful that they have contracted a disease which they regard as incurable. They are possessed by the popular ideas of syphilis which are dim reminiscences of the terrible forms of the malady that prevailed in centuries gone by, when its ravages and mortality were frightful. They must know whether or not they are infected. Scientific considerations have no weight with them, and they refuse to wait the requisite weeks or months that must elapse before the question can be absolutely decided. To be entirely frank with them means simply that

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they will go to some one else who is less scrupulously exact.

It thus becomes necessary, in the presence of a typical sclerosis, and before a single other syphilitic symptom has appeared, to diagnose the disease. Only with a very few extremely intelligent and docile patients can the exceptional possibilities be discussed. The percentage of error is a small one, and a mistake not only does not harm the patient, but can never be positively known. Cases occur in which the evidences of constitutional syphilis after an indurated sore are so slight and evanescent as to be unnoticed; treatment may prevent their occurrence entirely; prudence dictates the same precautions as to marriage, etc., after a hard lesion, no matter what its sequela; and proper treatment in no way injures the patient.

It is well for both parties concerned, however, to permit the patient to have some evidence of his infection other than the primary sore. It is difficult under any circumstances to persuade many of these patients to submit to treatment for the necessary time in a malady whose manifestations are often so slight, and whose intervals of apparently perfect health are often so long. Whilst therefore the diagnosis of syphilis can and must be made from the chancre alone, local treatment and tonic internal treatment only should be administered until some further manifestation of the disease, general adenopathy, angina, roseola, etc., appears.

One point of importance has been presupposed in the foregoing considerations. It is that the physician is perfectly familiar with the physical characteristics of the infecting sore. A typical tumor, perhaps exulcerated, with specific induration, must be present.

2. The laity consider syphilis an incurable disease, and a not inconsiderable proportion of syphilographers hold the same opinion. It is supported by the well-known facts of the occurrence of symptoms referable to the disease many years after the initial lesion; as is illustrated to an extreme degree by a celebrated case of Fournier's: primary and secondary syphilis at 20, good health until 70, and then typical gummata. Mucous patches, squamous palmar affections, etc., may occur for many years after the chancre; and various lesions attributed to the remote effects of the virus, such as aortic aneurism and locomotor ataxia, may happen at any time. A certain number of such cases occur, no matter what treatment has been employed. These late lesions, however, present certain characters that differentiate them

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clearly from the earlier ones; and more especially the fact that they are non-contagious and non-transmissible. They are to be regarded rather as sequelæ, and are really no more a part of the original disease than is the otitis media purulenta twenty years later a part of the scarlatina that first caused it. Over and above all this, there are on record a few well authenticated cases of syphilitic reinfection which demonstrate that even from a rigidly scientific point of view some cases of syphilis, at all events, are cured.

Practically, however, and this is the only point of view with which we are at present concerned, the vast majority of our cases have no further trouble after going through the regular stages of the disease under the proper treatment. They never show any further signs of the malady; they marry and procreate healthy children. They are to all intents and purposes cured. And whilst we can never guarantee that no signs of the old infection will ever reappear, the chances of its doing so are so small that, as in the case of diagnosis of the disease from the chancre, we can afford to take the risk. A malady that shows no signs of existence for years is cured. Absence of symptoms, our only criterion of the presence of disease, for a sufficient length of time, means absence of disease. What that length of time should be is a matter that will be considered under a later heading.

We can then answer in the affirmative, syphilis is curable. And we can go further than that: we can say that syphilis is self curable. It runs a definite course, like the acuter exanthemata, smallpox, scarlatina and measles, to which it is nearly allied. Treatment hastens and facilitates its cure; but, treated or untreated, it runs its course in a certain, though undetermined space of time.

3. The question as to the best practical method of treating syphilis has been the subject of endless discussion. Metallic mercury and the iodides are admitedly the drugs to be employed; but their best method of administration is still a moot question. The only ones requiring consideration are that by the mouth, the favorite in America, England, and France; that by inunction, practiced largely upon the Continent of Europe; and that by subcutaneous, or rather by intra-muscular injection, which is being more and more extensively employed by syphilographers the world over. Each method has its advantages and disadvantages. Oral administration is easy and pleasant, and patients

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are used to it; but it is slow and uncertain in its effects; it is very liable to cause gastro-intestinal disturbance; above all, it exposes the patient to detection as being under treatment, and it to a certain extent removes the patient from the minute control and supervision of the physician. How many of our patients disappear after a few visits, satisfied with the possession of a remedy that will cause their symptoms to disappear; nay, how many of our prescriptions, hoary with long service, are doing duty or injuring patients whom the physician never sees? In syphilis as in gonorrhea, it is desirable both for the patient and for his medical attendant, that the treatment be controlled and administered by the physician.

Inunctions are quicker and more efficacious, but is dirty and troublesome, and is very liable to cause salivation. The average American patient will not carry it out for any length of time. And of all methods it is the one that can be least successfully kept secret, which renders it entirely inapplicable in a large number of cases.

The injection method involves a slight amount of pain; but this becomes infinitessimal when skill and rapidity in making the injections is acquired. Abscesses and even painful indurations are so rare when properly employed that they become negligable quantities; and the few more serious accidents that have been reported from Europe have never been seen here, have probably been due to faulty technique, and, as they have occurred only in the proportion of one to hundreds of thousands or millions of injections, they are not contraindications to the method. Its advantages are neatness and cleanliness, extreme rapidity and efficacy of action, the utmost secrecy, and above all, the retention of the patient under the control of the physician. It is the method that I generally employ; and I can testify to the fact that patients not only do not object to it, but that they are loud in their praises of its efficacy and of the convenience of their having to do nothing, not even carry about with them the tell-tale box of pills, during the course of their treatment. It is true that it entails a somewhat greater expense upon the patient; but that can hardly be termed an objection in addressing a medical audience. As a matter of fact our syphilitic patients on the average by no means pay sufficiently for the services received; the successful management of a case should certainly be worth as much to the practitioner as a capital operation.

A judicious combination of all three methods will be found

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most appropriate and useful, and it may be schematised as follows:

a, Internal medication, protoiodide or blue pill, for delicate patients and women, and gray powder or a solution of hyrgolum (a new soluble metallic mercury) for children.

b, Inunctions where more intense and rapid effects are required, and where for any reason injections cannot be used.

c. Intramuscular hypodermic injections as the method of injection and routine practice.

A word as to the method. I employ the ordinary glass and rubber pravay syringe, the most useful and lasting of them all; metallic mountings are bad. The needles are 1½ inches and of large caliber, the regulation "antitoxin needle" is about right. A new needle is used for each patient, and kept for him; in this way the frequent boiling and flaming of needles, which quickly ruins them, is avoided. The injection is made deep, the full length of the needle, into the muscles of the buttocks or those between the shoulder blades. Proper antiseptic precautions as to cleansing of the skin and care of the needle is of course employed, and the injection orifice is immediately covered with a piece of rubber plaster.

I use the insoluble mercurial salts exclusively, usually calomel in the form of a 10% suspension in albolene. The soluble salts are too painful, and they necessitate daily visits, few patients will submit to them. The suspension is kept in smallest homeopathic vials hermetically sealed. It is sterilised once by boiling in the vials, and will then keep indefinitely. A fresh one is employed for each injection.

The injections are given at intervals of from five to fifteen days, dependent upon the course of the disease and the persistence of slight local tenderness. From 3 to 10 minims (310 to 1 grain of calomel) is introduced each time. Eight to twelve injections constitute the usual course; but their number, as well as the frequency of course during the progress of the disease, is a matter of judgment in each individual case. Not the least important application of the injection treatment is as an aid to the potassium iodide treatment in the late obstinate and chronic lesions.

The iodide treatment of tertiary syphilis needs no recapitulation here. A few points only deserve mention. The only measure of the dosage of the iodide is the results obtained and the tolerance of the patient. The usual dosage is entirely too small.

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One hundred grains daily is a small dose; I frequently give 400 or 500 or more; and in one case of gumma of the meninges no result was obtained till the dosage reached 900 grains daily. Administration in milk, after meals, the maintenance of a recumbent position for a time after administration of the dose, sinapisms over the stomach, etc., may be necessary where large doses are required. The rectum may be employed to relieve the stomach, since the saturated solution of the iodide of potassium is absorbed equally well from both organs. In the patient above mentioned, who was comatose, half the amount was pumped into the stomach through a tube, and the rest into the rectum. Finally, the iodide of sodium may be born where the iodide of potassium is not; and, where neither can be administered in the requisite doses, the iodide of rubidium usually agrees, though it has the disadvantage of being very expensive in the amounts required.

4. There has lately been a tendency on the part of certain syphilographers to lengthen the time of treatment from the traditional two years to three or even five years. I cannot but think that this a mistake, both as a necessity or a possibility. The vast majority of our patients are cured, *i. e.*, have no further symptoms, after two years. It is hard enough to keep them under observation for even that length of time. The dictum of five years necessary treatment is equivalent with incurability in the minds of most men.

Of course I do not mean to assert that in some cases a longer time would not be better. We cannot definitely tell the moment when syphilis ends. We can not even tell when certain lesions, as the mucous patch, cease to be contagious. But we know that authenticated cases of transmission after two years of treatment are so rare as to prove the rule. And here, as in all things in connection with the disease, we must advocate only possibilities and necessities for the average case. My rule is that, after two years of proper treatment, and after the patient has had no symptoms of the disease for at least six months, to regard the patient as cured. I could point to many cases that have been long under observation to substantiate that position, and to but very few which run counter to it.

5. A contagious disease like syphilis, to which all human beings are liable at least once in a life time, can be checked in its spread only by segregation. If it were possible to isolate every case until its earlier contagious stages had run their course, the disease would disappear from off the face of the earth. Mani-

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festly, however, it is not possible. The contagious period lasts too long, and for long periods thereof the patients are apparently too well to submit to the necessary restrictions. Syphilis will probably last as long as the human race exists.

The general virulence of the disease, however, has undoubtedly been modified in the course of time by its very general spread throughout the civilized world. Its type has grown milder, and there are some cogent arguments to be cited in favor of syphilization, though not those advanced by Auzias Turenne, as there were for smallpox inoculation before the advent of cowpox inoculation or vaccination. Suffice it to say that the disease as we know it today is a very different malady from that pictured to us by the syphilographers of the sixteenth century, or occuring more recently in the Sandwich Islands and other communities virgin to the disease. The disease that was a veritable scourge in the middle ages is now, I do not hesitate to say it, less to be dreaded by the individual than malarial infection or chronic rheumatism. That this is due to a general permeation of the community with the virus is supported by the fact that analogous effects have occurred in other infectious diseases. Thus measles, ordinarily so mild, ravaged one of the Orkney Islands like a scourge and caused hundreds of deaths when introduced into a community where it had been unknown for generations.

Nevertheless, the dangers and disagreeabilities incident to syphilis are quite great enough to justify us to take all reasonable precautions to prevent its spread. They are not great enough, however, to make us treat the syphilitic as an outcast, and interfere more than to a minimum degree with his ordinary habits of life. The reasonable and necessary precautions I take to be the following:

a, The forbidding of intimate intercourse, sexual or other, with persons presumably non-syphilitic during the active stages of the disease, the first two years.

b, The use of special utensils for eating, cleansing, etc., during any period when contagious lesions of the skin or mucous membranes exist.

Rational and vigorous treatment of all local lesions is of course of the greatest importance, as it shortens the life of these eminently contagious affections, and thus diminishes the danger of spreading the disease.

These precautions being observed, the syphilitic may go about his ordinary business and lead his usual family and social life. Infection of relatives and friends will not occur. Family epidemics of the disease are very rare in this country, where the elementary rules of personal cleanliness and family hygiene are generally

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observed; so rare that I regarded a case of it that occurred under my observation some two years ago as worthy of record. (*New York Medical Journal*, March, 1898.) Thousands of cases occur all the time in families in which, the above ordinary precautions being observed, no further spread of the infection occurs.

The syphilitic is usually quite sufficiently depressed in spirits without making him feel that he is a pariah and an outcast from society. No single measure, I might almost say not even the administration of mercury, will do as much for our patients as our convincing them that the disease they are suffering from is a curable one, and does not necessarily invalidate him for life and put a stigma upon his offspring.

6. The sixth and last point, as to when a syphilitic may be considered cured to the extent that he can assume all the individual and social relationships of the non-infected individual, is one concerning which there is much difference of opinion among syphilographers. Certain factors must not be lost sight of, whatever our medical opinions may be. The first is that the patient without syphilitic symptoms for a certain length of time will consider himself cured, and will do as he likes to in any case. It is useless to tell a patient that he is still infectious, and to forbid marriage, when he sees around him married men with chronic palmar syphilides and chronic syphylitic glossitis with healthy wives and blooming children. And then again we must endeavor to restore the individual to full social life at the earliest opportunity that it is safe to do so.

There are authorities who set a limit of five or even more years as the minimum at whith marriage may be contracted after a hard chancre. The tendency in Germany is to lengthen the necessary time, rather than to shorten it. My own rule is the following: After proper treatment for the full time, two years, the patient may marry, provided that a full year has elapsed without the advent of a contagious lesion. This makes, in favorable cases, three years from the beginning of the disease. In the exceptional cases in which contagious or presumably contagious lesions appear during the third year the period must be lengthened.

This is to my mind as conservative a position as it is possible to take in view of all the factors concerned in the decision. It practically means that cases properly treated, and in which no contagious lesions have developed in a year, are to be regarded as cured. Practical experience shows that they are, at least in so far as communicating the diesease to others or to the offspring is concerned. From the patients point of view three years is a long time; but it is a sacrifice that he owes to his life partner, his posterity, and the community at large.

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When, as occasionally happens, the lesions, more especially of the mucous membranes, persist beyond the third year, the position of the medical adviser is a difficult one. They cease to be contagious after a certain time; but none can tell just when. Here the only safe stand to take is to refuse a decision, and lay the facts plainly before the patient. Our profession is burdened with responsibility enough, and there are some phases and forms of it which we can justly lay upon the shoulders of the person immediately concerned in the matter.

In the foregoing paragraphs I have not attempted any exhaustive treatment of the questions involved. On each single one of them a lengthy paper might be written. 1 have merely endeavored to give the conclusions and to recount the practice that experience has taught me. I trust that their practical nature will be held to balance the many faults of omission of which I am sensible.

The following paper, by Dr. J. T. Axtell, Newton, Kas., on "Pott's Disease," was read by title:

This is a disease which was known to Hippocrates and is so familiar to all physicians that one hesitates to occupy your time with it.

Possibly we are inclined to overlook points in those diseases which seem common and a short review may be of use.

It is generally considered tubercular although the bacillus is not always found. It is a destructive ostitis and begins in the bodies of the vertebræ. There may be one or more than one involved. There is at first a small hyperemic spot in some part of the cancellous tissue. This spot grows larger and more red as the process extends and finally the centre becomes opaque and grayish while a zone of hyperemia surrounds it. If the tubercular bacilli are present they are found in the opaque or grayish substance. Degeneration of this centre may continue until the bodies of the vertebræ are destroyed and the surrounding tissues become involved. The circulation of surrounding parts may be interfered with causing further necrosis or atrophy. The ostitis may terminate at any time by resolution and ossification or may go on to suppuration and finally terminate by ossification and ankylosis. Older writers believed that that disease began in the intervertebral cartilage but this probably never occurs.

The original seat of the disease is uniformly in the bodies of the vertebræ. It may occur at any age but is most frequent in childhood. The largest percentage of cases occur at from three to ten years of age. It is equally common to boys and girls.

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Whether or not the disease begins with some traumatism which gives the bacilli a chance to begin destructive work has been much debated. Certain it is that a history of traumatism can often be obtained. Equally certain that when the disease occurs almost any enterprising parent can hunt up the history of injury.

The disease begins, however, where we would expect concussion. It is where the weight of the body is borne. Such histories as the following given by Moore are common. F. H., aged 32, when in perfect health fell backward from the side of a box car upon which he was climbing, striking in a sitting position. He suffered pain and gradual loss of health from that time on, and in the course of a few months had a well developed dorsal Pott's disease from which he finally died. On the other hand it often occurs in tubercular patients or in those whose health is not the best; it is often the sequela of measles or scarlet fever or some other debilitating disease and the probability is that the tubercular bacilli are always present in the body and that a traumatism or some disease which weakens resistance gives them their opportunity.

Further than this the principal office of the spine is weight carrying and the upright position is responsible for Pott's disease. It is said to never occur in quadrupeds. It is one of the penalties man pays for the upright position. A prominent New York orthopedist tersely says, "Man has lately assumed the upright position and both morally and physically he with difficulty maintains it."

The diagnosis of Pott's disease, which is so easy in the later stages, may be very difficult indeed in its incipiency. And this is when it is so important to make a diagnosis. It is to be remembered that rigidity of the spine, pain, attitude, gait, deformity and sometimes abscess and paralysis are the diagnostic points.

The child should be stripped and all his motions carefully watched as he walks or stoops to pick up something from the floor. He should be placed prone upon a table and his body raised by the heels to detect the slightest loss of flexibility of the spine which is the first and most constant and always present symptom. In the later stages when the loss of substance in the body of the vertebræ has caused the kyphosis, or posterior angular deformity, the diagnosis is easy. A record of the deformity should always be kept. This is best done by getting the exact shape of the spinal column with a strip of lead with the patient lying prone. It can then be cut from a piece of pasteboard and kept for reference. The cause being largely due to the weight of the body, it follows that one of the indications for treatment is recumbency. Prolonged rest in bed is good treatment for both adults and children. It is often wonderful how they will improve in weight

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and appearance and how the pain is relieved. The patient should not even be allowed to raise the head. In children a bed-frame or wire cuirass allows fresh air and sunshine. Of all the jackets and braces recommended but two classes need mention; they are the antero-posterior brace such as Taylor's, or the plaster of paris jacket of Sayer, which is also modified by being made of leather, felt, wood, metal and other material. When the disease is above the seventh cervical vertebra a jury mast or head rest must be used. This can be applied to any brace or jacket. Treatment cannot be expected to cure existing deformity. But further deformity may be prevented. Nature's method of cure is by ossification and ankylosis.

There are few diseases in which treatment is of so much benefit as in Pott's disease. Abscesses are the most dangerous complication. The surgical axiom that wherever pus is found it is to be evacuated does not apply there. These so-called abscesses do not contain true pus. It is an established fact that in a certain per cent. of the cases absorption will take place. After they are opened we usually get secondary infection. Yet if the abscess is rapidly or persistently increasing in size, or if the patient's health is failing, or when serious pressure symptoms are present, it is better to operate. Evacuation through a small incision with thorough washing with a bichloride solution and subsequent injection of iodoform emulsion and immediate hermetic sealing of the wound is good treatment. Aspiration is generally useless. In the lumbar region the pus usually lies at the heads of the psoas muscle and one may cut through or by the side of the quadratus lumborum.

Retro-pharyngeal abscesses are particularly grave as they may rupture in the throat and suffocate the patient. They may be opened by the head hanging over the end of the table, or an incision may be made along the posterior border of the sterno cleido mastoid. Paralysis usually recovers without any special treatment within from one to three years. Laminectomy has been done for it but is not now recommended at least until after this time has elapsed. About twenty-five per cent. of all cases of Pott's disease end fatally sooner or later. Modern treatment, however, is rapidly reducing this figure.

The following paper, by Dr. E. E. Hamilton, of Wichita, Kas., on "The Refraction of Trachomatous Eyes," was read by title:

In January, 1896, (see *Ophthalmic Record*), I reported the results of an examination of the refractive conditions of 190 trachomatous eyes. Many defects, both axial and curvature, were found, which might very properly be styled asthenopic errors. Their presence uncorrected in healthy eyes, would cause some uncomfortable symptoms of strain and prompt their possessor to seek relief.

Since then the pendulum of ocular sentiment has swung still further in the direction of emmetropia, until slight defects, particularly curvature, are recognized as fruitful sources of discomfort. The emmetropic eye is considered the ideal eye—the one best meeting the demands of modern civilization with least dan-

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ger of discomfort or damage. Its refractive condition is seldom changed and its functions seldom preverted, if its environments are at all favorable. Unfortunately it is the rare eye, compared with the hypermetropic and astigmatic one.

It is with a view of comparing the diseased trachomatous eye with the eye having no recognizable pathological changes, that I have pursued this investigation further. Evidently a healthy eye, needing a correction of refractive errors, will need it still more in the presence of organic changes, be they intra- or extra-ocular. Acting under this conviction it is my practice, as early in the disease as conditions permit, to work out carefully the refractive condition, calling to my aid the ophthalmometer, shadow test, and, when thought necessary, a cyclophlogic.

As will be seen many errors have been discovered, the correction of which, it has seemed to me, has placed the eyes in a condition best responding to treatment, besides lessening the liability of aggravating and dangerous relapses so common in this disease.

Errors of refraction invite contagious troubles, in that they furnish a soil more favorable to germ development. Conjunctival congestion, so frequent an attendant of occular defects, lessens tissue resistance and predisposes to the disease.

Since January, 1896, I have examined 125 trachoma cases representing 230 eyes, twenty of the number having for practical purposes one eye only. Eighty-five of these cases have been under treatment for the disease, while forty were pension applicants who were seen but once.

Of the 230 eyes, 200 (or 87 per cent.) were hypermetropic in both meridians, or hypermetropic in one meridian and emmetropic in the other. Twenty-five cases of simple hypermetropia, sixty-six cases of simple hypermetropic astigmatism, and 109 cases of conjunctival hypermetropic astigmatism—4 (or 17-10 per cent.) had mixed astigmatism, 23 (or 10 per cent.) were myopic in both or myopic in one meridian and emmetropic in the other. Eleven cases of simple myopia, eight of simple myopia astigmatism, and four of conjunctival myopia astigmatism.

One hundred and ninty-five (or 84 per cent.) were astigmatic. Of these 30 (or 15 4-10 per cent.) had oblique axes (145 degrees or 35 degrees). Ninety-two, (or 47 2-10 per cent.) had axes with, or approximating, the rule, while 73, (or 37 4-10 per cent.) were against or approximating against the rule.

Seventy-six cases had binocular astigmatism, 42 having symmetrical and 34 unsymmetrical axes.

Of the 34 having unsymmetrical axes, 15 required cylinders vertically placed in one eye and obliquely in the other; 6 had horizontal axes, their fellows being oblique; 4 had oblique and paral-

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lel; 8 had oblique axes not parallel, while one had a vertical axis, its fellow being horizontal.

Thirteen of my cases required glasses differently ground for each eye as follows:

Two had simple hypermetropia in one eye and simple hypermetropia astigmatism in the other; 1 had simple hypermetropia in one and compound hypermetropia astigmatism in the other; 4 had simple hypermetropia astigmatism in one and compound hypermetropia astigmatism in the other; 1 had simple myopia in one and simple hypermetropia astigmatism in the other; one had simple myopia astigmatism in one and simple hypermetropia astigmatism in the other, while one had mixed astigmatism in one and compound hypermetropia astigmatism in the other.

The 40 old soldiers had 72 eyes, eight of the number having only one eye of practical use. Of the 72 eyes, 51 were astigmatic, 4 myopic, 14 hypermetropic and 3 emmetropic. Of the astigmatic cases 15 7-10 per cent. had oblique (135 degrees or 45 degrees) axes, 41 1-10 per cent. were against and 43 2-10 were with the rule. Twenty-two cases had binocular astigmatism, fifteen having symmetrical and seven unsymmetrical axes.

These cases represented the disease in all its stages. In practice a smaller percentage, in the stage of sequelæ, is constantly seen. Patients evidently are becoming educated to the necessity of early treatment. On the contrary the pension applicants, dating in most cases from army life, represented comparatively more of the serious organic changes.

Obviously many difficulties were found in examination and corresponding uncertainties as to exact measurements of errors. Corneal opacities, of different location and density were found. Old ulcerations and cicatrices had caused many irregularities of corneal curvature, manifested mainly by distorted images. Iritic complications were seen as well as deeper structural changes.

Notwithstanding these many difficulties I am persuaded fairly accurate results were obtained, existing conditions considered. They speak for themselves and need no comment.

Doubtless some of the curvature defects were acquired, the primary cause, in my opinion, being diminished corneal resistance, influenced secondarily by external and internal pressure.

If disease has weakened the vertical meridian its curvature will be increasd, and lid pressure will aid in the result. If the horizontal meridian be weakened its curvature will be increased. Possibly here the lateral rectis aid in the result.

The unusual frequency of astigmatism against the rule, seemingly increasing as the diaease advances, suggests weakening of the horizontal corneal meridian, enough to more than counteract the opposite effects of increased lid pressure.

If astigmatism against the rule does occur with comparative

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more frequency in trachomatous than healthy eyes, can we account for it clinically? How often is seen at the border of a sharply defined pannus, stopping at or short of the horizontal meridian, an infiltration. This tends to assume a comparatively linear shape and disposes itself in a (or approximating) horizontal direction. Sometimes we find extensive destruction of corneal tissue, but oftener an exudate, which may break down forming superficial ulcers involving perhaps the epithelial layer only. Possibly this disposition to a linear, horizontal infiltration may tend to weaken this corneal meridian, causing increased curvature horizontally and diminished curvature vertically.

It would be interesting to know how stable are these acquired curvature effects. Does relieving lid pressure diminish acquired astigmatism with the rule? Does the absorption of exudates, healing of corneal ulcers and subsequent contraction of cicatrices lessen acquired errors, resulting from diminished corneal resistance? I am unable to answer from individual experience. Others having better opportunities for observing these cases, answer in the affirmative.

The following paper by Dr. C. M. Holcomb, Winfield, Kas., on "Tuberculocidin in the Treatment of Tuberculosis," was read by title:

In dealing with the subject of tuberculocidin in the treatment of tuberculosis it is not my intent or desire to enter into a discussion of tuberculosis, as to do so would be but to repeat that which has already been written. For the past two years I have treated the most of my cases of tuberculosis with tuberculocidin as prepared by Prof. Edwin Klebs.

Preparation: Tuberculocidin, or T. C. as usually and briefly spoken of, is prepared from cultures of tubercle bacilli or glycerinated bouillon. After five or six weeks there is an abundant surface growth, the virulency of which is tested by animal inoculation. The culture fluid remains clear, and after five to six weeks layers of bacilli begin to sink. It is at this time they are taken for this preparation of T. C. Kresol is now added to kill bacilli, mixing by shaking, and a room temperature is maintained for several days (this is the so-called cold extraction of bacilli, which differs from tuberculin, where extraction is made by boiling and antibodies probably destroyed); the cultures are now boiled in vacuo for successive hours, at a temperature ranging from forty to fifty degrees C. Filtration is then made of disintegrated baccilli and the filtrate treated with sodium bismuth iodide, precipitate of greater amount of toxic (alkaloid) substances, the clear filtrate is then treated with absolute alcohol which holds in solution certain other toxic substances and leaves

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the precipitation a whitish substance, an albumosis (soz albumosis) which is soluble in water. Solutions of this are tuberculocidin, the strength of which is determined by percentage of solid substance which it contains, usually being about one per cent. The theory of its action is based on the same principles which has been corroborated by animal experiments and seven years experience in the treatment of human tuberculosis by Prof. Edwin Klebs. This principle depends on the necessity of elimination of the toxins, which made the trial of Koch's tuberculin in man so dangerous. Every organism forms by metabolism substances poisonous to itself, the so-called autoxins or self-poisons. We find in the excrementitious products of tubercle bacilli such substances which destroy these organisms but are beneficial to tuberculous patients—animal experiments show this to be the case. Certain substances in the cultures of tubercle bacilli have a bacteria killing or bactercide power, and if we eliminate the toxins from such cultures they must be valuable for therapeutical use. Prof. Klebs discovered that this elimination of the toxic principles can be effected by the action of sodium bismuth iodide. Tuberculocidin can be used in all forms of tuberculosis in which the toxic effects of the tubercular virus have not yet markedly developed, and in which slight fever only is present, the vital forces being well preserved; those cases accompanied by fever and cachexia may not always tolerate it. Sometimes it provokes fever due to destruction of tubercle-bacilli, thus liberating their poisonous substances. In most cases it is necessary to accustom the patient to it by small doses continued for a long time. Under such circumstances the natural resistance of the body must be increased by hygienic and dietetic measures, such as are usually carried out in well regulated sanitariums. Accompanied by such favorable measures we have in the tuberculocidin a most valuable remedy.

Rules for its Administration, as laid down by Prof. Klebs are:

1. Always commence with small doses.
2. If the first injection is not followed by an elevation of temperature of more than one degree F. give the next higher dose on the following day. In cases of higher temperature give the same dose as long as the slightest elevation of temperature takes place.
3. If the smallest dose will not be tolerated, institute first the hygienic treatment mentioned above, including careful cleansing of the mouth and air passages. It will very rarely be necessary to add internal treatment by antiseptic and antifebrile drugs; cold sponging, douches, shower baths and rest are usually sufficient to control the fever.

Dosage.—The initial dose is one and a half minims and the daily increase is the same until the maximum dose is attained which is thirty (30) minims daily, while fifteen (15) minims daily is the medium dose.

Time Required.—From two to four months is required in an average case and from 100 to 200 C. C. will be needed. In many cases it will be necessary to repeat this treatment after a period of several months rest, and also 'tis best to repeat the following year for a month or more—some cases will require repetition for several years. Klebs reports cases thus treated for from four to six years. Other cases seem to be cured after one course of treatment. Patients who have been fully instructed with the treatment may apply the after treatments themselves by rectal injections, so their usual avocations are not interfered with, needing only the

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supervision of their medical adviser. Children by preference should be given the rectal injections.

Clinical Reports.—Miss E. D., age 27—family history good—no tubercular taint. In 1895 complained some of cough and quite free expectoration in the morning. In the latter part of 1895 she noticed some fever in the afternoon of each day and some loss of flesh. This condition continued through the following year so that her weight was reduced from 147 pounds to 117 pounds; gastric disturbances, loss of appetite and occasional vomiting of food in the morning. She had up to this time held a responsible position for a firm in Los Angeles, California, and on the advice of her physician resigned it and returned to her home at Winfield. In August, 1897, she came under my care, and on examination I found a marked dullness of apex of left lung, some crepitant rales, pulse 110; temperature 101½ F. Bowels were constipated much of the time, occasionally diarrheal attacks. She complained of much pain and throbbing of the rectum after each movement of the bowels, which on examination was found to be caused from an ulcer. Microscopical examination of sputum revealed the presence of tubercle bacilli, averaging five to the field. Scrapings from the ulcer also revealed their presence. She was placed under the usual hygienic treatment, cold baths, out door exercise and also dietetic regulation; internal treatment consisted of syr. of hypophosphites, with the addition of codeine for the very troublesome cough. On the 24th of August, commenced injections hypodermically of T. C., minimum dose 1½ m., increasing daily by 1½ m. until we reached 15 m., when marked reaction occurred; this was the maximum dose as she would not bear and did not, throughout the treatment, an increase. At the end of ten days the pulse and temperature fell to 95 and 100½ respectively. At the close of 30 days pulse 90, temperature 99 F., weight 120 pounds, a gain of three pounds. Ulcer of bowel healed, bacilli tubercle still present in the sputum, but lessend in number. At the end of 60 days pulse ranged from 80 to 83; temperature in the morning subnormal and evening 99 F.; weight 127 pounds. This marked improvement continued, and at the close of 90 days we had a normal pulse and temperature and weight of 137 pounds. No rales, no cough. The last injection was given November 27, 1897, the case being dismissed at that time, as no tubercle bacilli had been discovered in sputem for over a month, and she had regained her former weight of 147 pounds, and as she remarked, never felt better in her life. While she has been under observation up to the present time no sign of recurrence has occurred and I believe the case to be fully and absolutely cured. I can report seven other cases with as good results, one of them having a small cavity formation in right lung. In those advanced cases, with mixed infection I have seen no good results; and none is to be expected either in those rapid cases or so-called quick consumption. I have tried it on four such cases and the results were nil. In localized tubercular bases as of joints or in lupus, I have not given it a trial, but believe it would be of great value. Tuberculocidin is certainly an addition to our armamentarium in the treatment of certain forms of tuberculosis and is certainly entitled to a trial.

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Akers, Geo. W..... ..Stafford
Allen, F. T.....Neodesha
Adams, Harriet E....Topeka

Bryan, J. D. .....Ottawa
Black, R. S. .....Ottawa
Basham, D. W.....Neal
Boone, Wm. W,.....Highland
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Bower, W. C.....Lebanon
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Bannister, J. M.....Ft. Leavenworth
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Coldren, E. V.....Topeka
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Gundry, A. E.....St. Marys
Goddard, C. C.....Leavenworth
Green, D. E.....Pleasanton

Hartwell, Geo. N.....Jamestown
Hamell, Thos.....Olathe
Hamilton, E. E.....Wichita
Hissem, H. Z.....Ellsworth
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Hastings, H. E.....Olathe
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Jermane, P. L .... ..Holton
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Judd, C. E.....Topeka

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Longenecker, D. F...Emporia
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Munn, L. H.....Topeka
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